

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13032

Reg. Dist. No.

237

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 13044 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. at Pen. Gen. Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pittsville d. STREET ADDRESS Route U.S. # 50 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ARTHUR Middle GREENSBURY Last ADKINS		4. DATE OF DEATH Month DEC. Day 31st Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 24, 1902
9. AGE (In years last birthday) 54 yrs.		10. IF UNDER 1 YEAR Months 8 Days 7	11. IF UNDER 24 HRS. Hours 7 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Farmer	
11. BIRTHPLACE (State or foreign country) R.D.# 1 Pittsville, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Ernest Mitchell Adkins		14. MOTHER'S MAIDEN NAME Belle Freeny	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO. Unk	
17. INFORMANT Mrs. Mildred Hales (Daughter)		18. ADDRESS Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid hemorrhage 443X DUE TO Hypertensive C.V. Disease Conditions, if any, which gave rise to immediate cause (b) 12 yrs. (c) 12 yrs. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 12 yrs.		INTERVAL BETWEEN ONSET AND DEATH 12 yrs.	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Dr. Earl L. Royer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. Earl L. Royer		DATE SIGNED Jan. 2 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 4, 1957	22c. NAME OF CEMETERY OR CREMATORY Parsonsbury Cemetery	22d. LOCATION (City, town, or county) (State) Parsonsbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		24a. REC'D BY REGISTRAR JAN 7 1957	24b. REGISTRAR'S SIGNATURE Mary T. Holloway

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATEMENT OF HEALTH—LAWSON 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

JAN 7 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13083

CERTIFICATE OF DEATH

13033

Reg. Dist. No. 337

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pittsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pittsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Route # 50		d. STREET ADDRESS U.S.# Route #50	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HOMER Middle FRANK Last ADKINS		4. DATE OF DEATH Month DECEMBER Day 16th Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 3, 1898
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months 3 Days 13	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian State Armory Salisbury, Md.		10b. KIND OF BUSINESS OR INDUSTRY Wango, Maryland	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Elisaha Franklin Adkins		14. MOTHER'S MAIDEN NAME Mary Elizabeth Smullen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Unk		16. SOCIAL SECURITY NO. 	
17. INFORMANT Mrs. Dollie M. Adkins (Wife)		Address Route #50 Pittsville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Occlusion (thrombosis) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerosis DUE TO (c) 			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. 19 p. m. 		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State) 	
21. I certify that I attended the deceased from 12-16-56 , to 12-16-56 , that I last saw the deceased alive on 12-16-56 , and that death occurred at 11:45P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Willards, Maryland DATE SIGNED Dec. 17 1956			
ACTUAL SIGNATURE Frank R. Lewis		M.D. Willards, Maryland	
PHYSICIAN'S NAME (Type) Dr. Frank R. Lewis		M.D. 	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 19, 1956	
22c. NAME OF CEMETERY OR CREMATORY Pittsville Cemetery		22d. LOCATION (City, town, or county) (State) Pittsville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		24a. REC'D BY REGISTRAR DEC 26 1956	
24b. REGISTRAR'S SIGNATURE Mary K. Hallways			

CERTIFICATE OF DEATH

File No. 10

Name of Deceased		Sex		Age	
Date of Death		Place of Death		Cause of Death	
Occupation		Manner of Death		Signature of Physician	
Signature of Registrar		Date of Registration		Place of Registration	
Signature of Coroner		Date of Coroner's Report		Place of Coroner's Report	
Signature of Medical Examiner		Date of Medical Examiner's Report		Place of Medical Examiner's Report	
Signature of Pathologist		Date of Pathologist's Report		Place of Pathologist's Report	
Signature of Anatomist		Date of Anatomist's Report		Place of Anatomist's Report	
Signature of Surgeon		Date of Surgeon's Report		Place of Surgeon's Report	
Signature of Dentist		Date of Dentist's Report		Place of Dentist's Report	
Signature of Pharmacist		Date of Pharmacist's Report		Place of Pharmacist's Report	
Signature of Nurse		Date of Nurse's Report		Place of Nurse's Report	
Signature of Hospital		Date of Hospital's Report		Place of Hospital's Report	
Signature of Family		Date of Family's Report		Place of Family's Report	
Signature of Community		Date of Community's Report		Place of Community's Report	
Signature of State		Date of State's Report		Place of State's Report	
Signature of Nation		Date of Nation's Report		Place of Nation's Report	
Signature of World		Date of World's Report		Place of World's Report	

BUREAU V. S.

JEC 26 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

13045

13035

337

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>WORCESTER</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>3 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Pocomoke</u>		<u>232-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>RT. #1</u>			
3. NAME OF DECEASED (Type or Print) (First) <u>Annie</u> (Middle) <u>B.</u> (Last) <u>ATKINSON</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>December 8</u> 19 <u>56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Feb 22, 1874</u>	9. AGE last birthday <u>82</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frank B. Maddox</u>				14. MOTHER'S MAIDEN NAME <u>Sophia Pusey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Edgar W. Atkinson, Pocomoke</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
332X IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u>						<u>5 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cerebral Arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Myocardial Insufficiency</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Arteriosclerotic Heart Disease</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 7</u> , 19 <u>56</u> , to <u>Dec 8</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec 7</u> , 19 <u>56</u> , and that death occurred at <u>12:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>Salisbury Md.</u>		DATE SIGNED <u>Dec 8 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/10/56</u>		NAME OF CEMETERY OR CREMATORY <u>Salem Methodist</u>		LOCATION (City, town, or county) (State) <u>Pocomoke, Md.</u>	
24. REC'D BY REGISTRAR <u>11-11-1956</u>		REGISTRAR'S SIGNATURE <u>Mary H. Hollaway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Henry H. Watson</u>		ADDRESS <u>Pocomoke Md.</u>	
DATE							

CERTIFICATE OF DEATH

Form 1-5-55

1. NAME OF DECEASED (Print or Write)

2. SEX

3. AGE

4. PLACE OF BIRTH

5. DATE OF BIRTH

6. DATE OF DEATH

7. PLACE OF DEATH

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE OF PHYSICIAN

11. MEDICAL EXAMINATION

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF DECEASED

15. SIGNATURE OF PHYSICIAN

16. SIGNATURE OF REGISTRAR

17. SIGNATURE OF WITNESSES

18. SIGNATURE OF DECEASED

19. SIGNATURE OF PHYSICIAN

20. SIGNATURE OF REGISTRAR

21. SIGNATURE OF WITNESSES

22. SIGNATURE OF DECEASED

23. SIGNATURE OF PHYSICIAN

24. SIGNATURE OF REGISTRAR

25. SIGNATURE OF WITNESSES

26. SIGNATURE OF DECEASED

27. SIGNATURE OF PHYSICIAN

28. SIGNATURE OF REGISTRAR

29. SIGNATURE OF WITNESSES

BUREAU V. S.

DEC 11 1956

RECEIVED

RECEIVED

This certificate is to be filled out by the physician or other person who has attended the deceased or who has been informed of the cause of death. It should be filled out as soon as possible after death and should be filed in the office of the Registrar of the State Department of Health. The certificate should be filled out in duplicate and the original should be filed in the office of the Registrar. The duplicate should be filed in the office of the physician or other person who has attended the deceased or who has been informed of the cause of death. The certificate should be filled out in duplicate and the original should be filed in the office of the Registrar. The duplicate should be filed in the office of the physician or other person who has attended the deceased or who has been informed of the cause of death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 392

13046

13036

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>11 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>733 S. Division St.</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>733 S. Division St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) First <u>Elsie</u> Middle <u>Moore</u> Last <u>Betts</u>				4. DATE OF DEATH Month <u>12</u> Day <u>10</u> Year <u>19 56</u>															
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 14, 1893</u>		9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>				11. BIRTHPLACE (State or foreign country) <u>Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>William E. Moore</u>						14. MOTHER'S MAIDEN NAME <u>Margaret Beale</u>													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>212-03-3484</u>				17. INFORMANT <u>Margaret Groten- same.</u>				Address <u> </u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.0</u> DUE TO <u>Arterio-sclerotic Heart Dis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>												INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>yes -</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>															
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>Earl L. Royer</u>						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						DATE SIGNED <u>12-10-56</u>							
EXAMINER'S NAME (Type) <u>Earl L. Royer</u>				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>										22b. DATE THEREOF <u>12/12/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hill & Johnson Co. 705 E. Main St, Salisbury, Maryland</u>						ADDRESS		24a. REC'D BY REGISTRAR <u>12-11-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>									

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
DEC 14 1956
BUREAU V. B.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13037

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fruitland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fruitland</u>	
c. LENGTH OF STAY IN 1b <u>5 Yrs.</u>		d. STREET ADDRESS <u>Box 295</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Box 295</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Matej</u> Middle <u>Martin</u> Last <u>Bohnak</u>		4. DATE OF DEATH Month <u>12</u> Day <u>4</u> Year <u>19 56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 10, 1883</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Coal miner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>Austria</u> ✓	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Joseph J. Bohnak</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Burns of 100 % of body surface</u> 916.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Clothing caught fire while burning trash.</u>	
20c. TIME OF INJURY Month, Day, Year <u>4:30 P.m. 12-4-56 19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Fruitland</u> (County) <u>Wicomico</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Earl L. Royer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-7-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>		22d. LOCATION (City, town, or county) <u>Salisbury, Maryland</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill & Johnson Co. Salisbury, Maryland</u>		24a. REC'D BY REGISTRAR <u>12-7-56</u>	
24b. REGISTRAR'S SIGNATURE <u>Norman T. Baker</u>			

WISCONSIN STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
DEC 10 1956
BUREAU-V. 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18				13038	
4-9-57L				8,9:G213	
13047				CERTIFICATE OF DEATH	
Reg. Dist. No.					
1. PLACE OF DEATH a. COUNTY Wicomico		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
c. LENGTH OF STAY IN 1b		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Hen. Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
3. NAME OF DECEASED (Type or print) First ELEANOR Middle BREEN Last BREEN		4. DATE OF DEATH Month DECEMBER Day 15th Year 1956		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1904 February 15, 1904	9. AGE (In years last birthday) 52 53 yrs.	IF UNDER 1 YEAR Months 10 Days 0 Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Hartford, Conn.	
13. FATHER'S NAME William Sinnott		14. MOTHER'S MAIDEN NAME Anna Nolan		12. CITIZEN OF WHAT COUNTRY? U S A	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Thomas F. Breen (Husband) Address Clyde Ave. (Fruitland) Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident with left hemiplegia and subarachnoid bleeding. 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Vascular Disease (?) DUE TO (c) 				INTERVAL BETWEEN ONSET AND DEATH 3 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 8:30 PM	
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from 12/15 , 19 56 , to 12/15 , 19 56 , that I last saw the deceased alive on 12/15 , 19 56 , and that death occurred at 8:30 PM , from the causes and on the date stated above.					
ACTUAL SIGNATURE Dr. Rufus S. Gardner Jr.		ADDRESS (Street, city or town, state) S. Division St. (Office) Dec. 17 1956			
PHYSICIAN'S NAME (Type) Dr. Rufus S. Gardner Jr. M.D.		DATE SIGNED Dec. 17 1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 20, 1956		22c. NAME OF CEMETERY OR CREMATORY Mt. St. Benedict Cemetery	
22d. LOCATION (City, town, or county) (State) Hartford, Conn.					
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		ADDRESS 		24a. REC'D BY REGISTRAR DEC 19 1956	
24b. REGISTRAR'S SIGNATURE Mary H. Holloway					

RECEIVED

DEC 20 1956

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13039

13048

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Reside before admission) Former Res. Of Salisbury Md. Sussex Co. Del.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parents Now live Seaford Delaware.	
d. NAME OF HOSPITAL (If not in hospital, give street address) Pen. Gen. Hospital		e. STREET ADDRESS 312 Sussex Ave.	f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) (BABY) Jeffery Lynn		4. DATE OF DEATH Month DECEMBER Day 20 Year th 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 10. 1956.
9. AGE (In years last birthday) yrs. 1 Months 10 Days 19 Hours 56		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
11. BIRTHPLACE (State or foreign country) P.G. Hospt. Salisbury, Md.		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME Robert Calhoun		14. MOTHER'S MAIDEN NAME Ethel M. Sexton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Robert O. Calhoun, (Father)		Address 312 Sussex, Ave. Seaford, Delaware.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 756.2 DUE TO Thoracic stomach Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Operation for esophageal atresia (c) Cardiac failure due to patent ductus arteriosus			
INTERVAL BETWEEN ONSET AND DEATH 1 wk 5 1/2 wks 5 1/2 wks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cardiac failure due to patent ductus arteriosus			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 12 Nov. 1956 , to 20 Dec. 1956 , that I last saw the deceased alive on 20 Dec. 1956 , and that death occurred at 8:15P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Eugene J. Linberg		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) Dr. Eugene J. Linberg.		Salisbury, Maryland.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 23. 56.	22c. NAME OF CEMETERY OR CREMATORY Wicomico Mem. Park Cemetery, Salisbury, Maryland.	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE Holloway & Co.		ADDRESS Salisbury, Maryland.	
24a. REC'D BY REGISTRAR DEC 27 1956		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

2082244XV4

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES J. BROWN		2. SEX Male		3. AGE 45	
4. DATE OF DEATH Dec 20 1956		5. TIME OF DEATH 10:30 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Myocardial Infarction		8. MANNER OF DEATH Natural		9. PLACE OF BIRTH Boston, Mass.	
10. OCCUPATION Salesman		11. MARITAL STATUS Married		12. EDUCATION High School	
13. PREVIOUS ILLNESS Hypertension		14. MEDICAL HISTORY None		15. SIGNATURE OF PHYSICIAN J. J. Smith	
16. SIGNATURE OF REGISTRAR A. B. C.		17. SIGNATURE OF WITNESS D. E. F.		18. SIGNATURE OF DECEASED James J. Brown	

BUREAU V. 3

DEC 27 1956

RECEIVED

1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.
VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 332

13040

13049

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>DELAWARE</u> COUNTY <u>SUSSEX</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>SALISBURY</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>FRANKFORD.</u>		46x-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PENINSULA GENERAL Hospital</u>				STREET ADDRESS <u>Rt. 2</u>		(If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>BABY BOY CAREY.</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>December 16 1956</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>SINGLE</u>	8. DATE OF BIRTH <u>December 11-1956</u>	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>CLAYTON JAMES CAREY</u>				14. MOTHER'S MAIDEN NAME <u>DOROTHY CARMELA CULLEN.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>CLAYTON CAREY FRANKFORD DEL.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
760.0 IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage Diffuse</u>				INTERVAL BETWEEN ONSET AND DEATH <u>life</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Claudia</u>				<u>Pregnant</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Plac. Separation, cord Prolapse</u>				<u>Postnatal</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Foetal Breech, Pre-viable Premature</u>				<u>Birth</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at....., 19....., from the causes and on the date stated above.							
SIGNATURE <u>Alfonse Christensen</u>				ADDRESS (Street, city, town, state) <u>12/17/56</u>			
M. D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>12/17/56</u>		NAME OF CEMETERY OR CREMATORY <u>BETHEL CEMETERY OCEAN VIEW. DEL.</u>		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR DATE <u>12 20 56</u>		REGISTRAR'S SIGNATURE <u>Mary W Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Ronald James Milledge</u>		ADDRESS	

2082253XV0

CERTIFICATE OF DEATH

1953

DECEASED

FRANK J. RYAN

RT. 2

December 10, 1953

Cared

December 1, 1953

Wiscamisco

SALISBURY

General Hospital

MALE WHITE

CLAYTON JAMES CARED

DOROTHY CARMELA C. LLEN

BUREAU V. 3

DEC 26 1956

9:22

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13050

Reg. Dist. No.

13041

382

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fruitland</u>		c. LENGTH OF STAY IN 1b <u>6 Hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>RICHARD</u> Middle <u>NORMAN</u> Last <u>CAREY</u>		4. DATE OF DEATH Month <u>12</u> Day <u>19</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 6, 1918</u>
9. AGE (In years last birthday) <u>38</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Produce</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wholesale</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Norman W. Carey</u>		14. MOTHER'S MAIDEN NAME <u>Hilda Acworth</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or partial) <u>NO</u>		16. SOCIAL SECURITY NO. <u>219-07-2605</u>	
17. INFORMANT <u>Mrs. Etta B. Carey, Same</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12-18</u> , 19 <u>56</u> to <u>12-19-56</u> , that I last saw the deceased alive on <u>12-19-56</u> , 19 <u>56</u> , and that death occurred at <u>6:10 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Lee L. Lawry</u> M.D.		ADDRESS (Street, city or town, state) <u>Fruitland, Md.</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Dr. Lee Lawry, Main St. Fruitland Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/21/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Fruitland, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill & Johnson Co. Salisbury, Maryland</u>		24a. REC'D BY REGISTRAR <u>12-20-56</u>	24b. REGISTRAR'S SIGNATURE <u>Mary W. Holliday</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEC 26 1956

RECEIVED

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

13042

CERTIFICATE OF DEATH

13051

Reg. Dist. No. 337

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>MARYLAND</u>		COUNTY <u>WORCESTER</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>SALISBURY</u>		LENGTH OF STAY (in this place) <u>5 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>SNOW HILL</u>		<u>238-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PENINSULA GENERAL HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>R.R. 2</u>			
3. NAME OF DECEASED (Type or Print) <u>JENNIE M. CARMEAN</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>DECEMBER 15 19 56</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>June 1 - 1883</u>	9. AGE last birthday <u>73 6/14</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Snow Hill, Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Thomas W. Mainier</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mr. Roger Pharrman, Snow Hill, Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.2 IMMEDIATE CAUSE (A) <u>Degenerative Heart Disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....<u>5 A.</u>.....M, from the causes and on the date stated above.							
SIGNATURE <u>Willie R. Ellis, Jr.</u> M.D.				ADDRESS (Street, city, town, state) <u>Salisbury, Md.</u>		DATE SIGNED <u>12-15-56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Dec. 17/56</u>		NAME OF CEMETERY OR CREMATORY <u>Bates Cemetery</u>		LOCATION (City, town, or county) (State) <u>Snow Hill, Md</u>	
24. REC'D BY REGISTRAR <u>Mary Holloway</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Mary Chumley</u>		ADDRESS <u>Snow Hill, Md</u>	
DATE <u>DEC 18 1956</u>							

CERTIFICATE OF DEATH

Page One

1. NAME OF DECEASED (Print or Type)

MARYLAND

COUNTY OF

DATE

DATE OF DEATH

Thymic Hyperplasia

BUREAU V. 3

DEC 17 1956

RECEIVED

Ballentine

William B. Allen, Jr.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

13052

13043

332

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		TOWN		TOWN	
TOWN <u>Salisbury</u>		<u>Most of life</u>		STREET ADDRESS (If rural give location)		STREET ADDRESS	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>At home - 304 Delaware St.</u>				<u>304 Delaware Street</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Annie Maria Cottman</u>				<u>12 - 5 - 19 56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>A.A.</u>	<u>Widow</u>	<u>3-3-1876</u>	<u>80 yrs.</u>	Months <u>7</u>	Days <u>2</u>	Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Domestic</u>		<u>Housework</u>		<u>Fruitland, Wicomico Co. Md.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Christopher</u>				14. MOTHER'S MAIDEN NAME <u>Anne Pollitt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>No</u>		<u>Mrs. Juanita Conway, Fruitland, Md.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				<u>Arterio sclerotic Heart Disease</u>			
2. IMMEDIATE CAUSE (A)				<u>Arteriosclerosis</u>			
3. ANTECEDENT CAUSE(S) DUE TO				<u>Arteriosclerosis</u>			
4. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				<u>Arteriosclerosis</u>			
5. STATING UNDERLYING CAUSE LAST, DUE TO				<u>Arteriosclerosis</u>			
6. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>10 months</u>			
7. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>Indefinite</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5 Feb</u> , 19 <u>56</u> , to <u>5 Dec</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5 Dec</u> , 19 <u>56</u> , and that death occurred at <u>4:30</u> M., from the causes and on the date stated above.							
SIGNATURE <u>J. F. Stewart</u>				DATE SIGNED <u>5 Dec 1956</u>			
ADDRESS (Street, city, town, state) <u>Salisbury Md</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12-9-56</u>		<u>Green Acres Mem. Park</u>		<u>Salisbury, Wicomico Co., Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>DEC 11 1956</u>		<u>Mary H. Holloway</u>		<u>J. F. Stewart Funeral Home, Salisbury, Md.</u>			

CERTIFICATE OF DEATH

Reg. Dist. No.

1. Name of deceased person on the date of death

2. Sex

3. Age

4. Race

5. Date of birth

6. Place of birth

7. Date of death

8. Cause of death

9. Date of burial

10. Name of funeral home

11. Name of physician

12. Name of hospital

13. Name of cemetery

14. Name of undertaker

15. Name of registrar

16. Name of informant

17. Name of witness

18. Name of doctor

19. Name of nurse

20. Name of attendant

21. Name of helper

22. Name of carrier

23. Name of driver

24. Name of porter

25. Name of janitor

26. Name of cook

27. Name of cleaner

28. Name of gardener

29. Name of painter

30. Name of plumber

31. Name of electrician

32. Name of carpenter

33. Name of mason

34. Name of bricklayer

35. Name of roofer

36. Name of painter

37. Name of decorator

38. Name of upholsterer

39. Name of furniture maker

40. Name of cabinet maker

41. Name of joiner

42. Name of cooper

43. Name of wheelwright

44. Name of blacksmith

45. Name of farrier

46. Name of saddler

47. Name of harness maker

48. Name of shoemaker

49. Name of hatter

50. Name of druggist

51. Name of pharmacist

52. Name of optician

53. Name of oculist

54. Name of dentist

55. Name of veterinarian

56. Name of farmer

57. Name of laborer

58. Name of clerk

59. Name of messenger

60. Name of porter

61. Name of janitor

62. Name of cook

63. Name of cleaner

64. Name of gardener

65. Name of painter

66. Name of plumber

67. Name of electrician

68. Name of carpenter

69. Name of mason

70. Name of bricklayer

71. Name of roofer

72. Name of painter

73. Name of decorator

74. Name of upholsterer

75. Name of furniture maker

76. Name of cabinet maker

77. Name of joiner

78. Name of cooper

79. Name of wheelwright

80. Name of blacksmith

81. Name of farrier

82. Name of saddler

83. Name of harness maker

84. Name of shoemaker

85. Name of hatter

86. Name of druggist

87. Name of pharmacist

88. Name of optician

89. Name of oculist

90. Name of dentist

91. Name of veterinarian

92. Name of farmer

93. Name of laborer

94. Name of clerk

95. Name of messenger

96. Name of porter

97. Name of janitor

98. Name of cook

99. Name of cleaner

100. Name of gardener

101. Name of painter

BUREAU V. S.

DEC 11 1956

RECEIVED

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13044

13053

CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 15 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		d. STREET ADDRESS 226 Monticello Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 226 Monticello Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Bertha M. Middle Culver Last		4. DATE OF DEATH Month Dec. Day 19 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 9, 1878
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk, Sales (ret.)		10b. KIND OF BUSINESS OR INDUSTRY Retail Grocery	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Bayard Nichols		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 181-22-2834	
17. INFORMANT George A. Culver,		22b. DATE THEREOF 12/23/56	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Sudden yes		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan , 19 53 to Dec , 19 56 , that I last saw the deceased alive on 16 Dec , 19 56 , and that death occurred at 1:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 407 Camden Ave DATE SIGNED 12-20-56 ACTUAL SIGNATURE Earl L. Royer M.D. PHYSICIAN'S NAME (Type) Earl L. Royer Salisbury, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22c. NAME OF CEMETERY OR CREMATORY Bridgeville	
22d. LOCATION (City, town, or county) (State) Bridgeville, Del.		23. FUNERAL DIRECTOR'S SIGNATURE Harvey Williams Bridgeville, Md. H. E. Williams & Son, Bridgeville, Del.	
24a. REC'D BY REGISTRAR 12-20-56		24b. REGISTRAR'S SIGNATURE Mary W. Holloway	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, MASS.

BUREAU V. S.

DEC 26 1956

RECEIVED

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, MASS.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13051

CERTIFICATE OF DEATH

13046 332
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eden	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Hill Private Sanitarium		d. STREET ADDRESS R.D. # 1	
3. NAME OF DECEASED (Type or print) First CLAYTON Middle E Last DYKES		4. DATE OF DEATH Month DEC. Day 31 st Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 9, 1873
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months 8 Days 22	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Farmer	11. BIRTHPLACE (State or foreign country) Eden, Maryland
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Henry Dykes	
14. MOTHER'S MAIDEN NAME Charlotte (UnK)		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk	
16. SOCIAL SECURITY NO. 		17. INFORMANT Mrs. Agnes Greenberger (Daughter) Address W. College Ave. Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebro Vascular Accident 331X DUE TO (b) Senility Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) Hypertension			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 12/14 , 19 55 , to 12/26 , 19 56 , that I last saw the deceased alive on 12/26 , 19 56 , and that death occurred at 9:55 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. Andrew Mitchell		ADDRESS (Street, city or town, state) Salisbury, Maryland	
PHYSICIAN'S NAME (Type) Dr. Andrew Mitchell		M.D. Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 3, 1957	22c. NAME OF CEMETERY OR CREMATORY Zion Cemetery	22d. LOCATION (City, town, or county) (State) R.D. # Fruitland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		24a. REC'D BY REGISTRAR Jan 7 1957	
24b. REGISTRAR'S SIGNATURE Mary J. Holloway			

RECEIVED
JAN 7 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13055 CERTIFICATE OF DEATH

Reg. Dist. No.

13047
332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 3½ yrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Denton, Md.		d. STREET ADDRESS RFD 2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SADIE Middle IVA Last HARCUM		4. DATE OF DEATH Month Dec. Day 3rd, Year 19 56	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 19, 1890
9. AGE (In years lost birthday) 66 yrs.		10. IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Haynes		14. MOTHER'S MAIDEN NAME Mary Jane Beulah	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. 220-05-1862	
17. INFORMANT Hospital Records - Salisbury, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Recurrent cerebral thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, general DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic cardiovascular disease; pyelonephritis			
INTERVAL BETWEEN ONSET AND DEATH 3 weeks ?			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour _____ o. ft. _____ p. m. _____ Month _____ Day _____ Year _____		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from May 13 , 19 56 , to Dec. 3 , 19 56 , that I last saw the deceased alive on Dec. 3 , 19 56 , and that death occurred at 11:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Dr. Juerman M.D. Deer's Head State Hospital 12/4/56 PHYSICIAN'S NAME (Type) V. Juerman, M. D. Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 9, 1956	
22c. NAME OF CEMETERY OR CREMATORY Saint Paul Cemetery		22d. LOCATION (City, town, or county) Near Federalsburg, Maryland (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton and Son, Federalsburg, Md.		24a. REC'D BY REGISTRAR DATE 12-7-56	
24b. REGISTRAR'S SIGNATURE Mary W. Holloway			

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. DATE OF DEATH April 4, 1968		5. TIME OF DEATH 2:01 PM		6. PLACE OF DEATH Room 306, Airport Hotel, Memphis, Tennessee	
7. CAUSE OF DEATH Suicide by gunshot		8. MANNER OF DEATH Homicide		9. PLACE OF BIRTH Sikeston, Missouri	
10. OCCUPATION Member of the Senate		11. EDUCATION High School Graduate		12. RELIGION Methodist	
13. MARITAL STATUS Single		14. SOCIAL SECURITY NUMBER [REDACTED]		15. DATE OF BIRTH April 24, 1933	
16. SIGNATURE OF DECEASED [Signature]		17. SIGNATURE OF WITNESS [Signature]		18. SIGNATURE OF PHYSICIAN [Signature]	
19. SIGNATURE OF CORONER [Signature]		20. SIGNATURE OF JUDGE [Signature]		21. SIGNATURE OF CLERK [Signature]	
22. SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]		23. SIGNATURE OF DECEASED'S NEXT OF KIN [Signature]		24. SIGNATURE OF DECEASED'S ATTORNEY [Signature]	
25. SIGNATURE OF DECEASED'S MINISTER [Signature]		26. SIGNATURE OF DECEASED'S CHURCH [Signature]		27. SIGNATURE OF DECEASED'S EMPLOYER [Signature]	
28. SIGNATURE OF DECEASED'S SCHOOL [Signature]		29. SIGNATURE OF DECEASED'S FRIEND [Signature]		30. SIGNATURE OF DECEASED'S NEIGHBOR [Signature]	
31. SIGNATURE OF DECEASED'S CO-EMPLOYEE [Signature]		32. SIGNATURE OF DECEASED'S CO-STUDENT [Signature]		33. SIGNATURE OF DECEASED'S CO-RESIDENT [Signature]	
34. SIGNATURE OF DECEASED'S CO-TRAVELER [Signature]		35. SIGNATURE OF DECEASED'S CO-PASSENGER [Signature]		36. SIGNATURE OF DECEASED'S CO-PILOT [Signature]	
37. SIGNATURE OF DECEASED'S CO-FLIGHT ATTENDANT [Signature]		38. SIGNATURE OF DECEASED'S CO-PORTER [Signature]		39. SIGNATURE OF DECEASED'S CO-PAKAGE HANDLER [Signature]	
40. SIGNATURE OF DECEASED'S CO-LOUNGE ATTENDANT [Signature]		41. SIGNATURE OF DECEASED'S CO-BARTENDER [Signature]		42. SIGNATURE OF DECEASED'S CO-WAITRESS [Signature]	
43. SIGNATURE OF DECEASED'S CO-COOK [Signature]		44. SIGNATURE OF DECEASED'S CO-BUSINESSMAN [Signature]		45. SIGNATURE OF DECEASED'S CO-PROFESSOR [Signature]	
46. SIGNATURE OF DECEASED'S CO-STUDENT [Signature]		47. SIGNATURE OF DECEASED'S CO-TEACHER [Signature]		48. SIGNATURE OF DECEASED'S CO-PRINCIPAL [Signature]	
49. SIGNATURE OF DECEASED'S CO-DEAN [Signature]		50. SIGNATURE OF DECEASED'S CO-VICE PRINCIPAL [Signature]		51. SIGNATURE OF DECEASED'S CO-CHURCHWARDEN [Signature]	
52. SIGNATURE OF DECEASED'S CO-PASTOR [Signature]		53. SIGNATURE OF DECEASED'S CO-DEACON [Signature]		54. SIGNATURE OF DECEASED'S CO-SINGER [Signature]	
55. SIGNATURE OF DECEASED'S CO-CHORIST [Signature]		56. SIGNATURE OF DECEASED'S CO-GRANDMASTER [Signature]		57. SIGNATURE OF DECEASED'S CO-MASTER [Signature]	
58. SIGNATURE OF DECEASED'S CO-VICAR [Signature]		59. SIGNATURE OF DECEASED'S CO-SENIOR WARDEN [Signature]		60. SIGNATURE OF DECEASED'S CO-JUNIOR WARDEN [Signature]	
61. SIGNATURE OF DECEASED'S CO-CHAIRMAN [Signature]		62. SIGNATURE OF DECEASED'S CO-VICAR GENERAL [Signature]		63. SIGNATURE OF DECEASED'S CO-DEACON GENERAL [Signature]	
64. SIGNATURE OF DECEASED'S CO-SINGER GENERAL [Signature]		65. SIGNATURE OF DECEASED'S CO-CHORIST GENERAL [Signature]		66. SIGNATURE OF DECEASED'S CO-GRANDMASTER GENERAL [Signature]	
67. SIGNATURE OF DECEASED'S CO-MASTER GENERAL [Signature]		68. SIGNATURE OF DECEASED'S CO-VICAR GENERAL [Signature]		69. SIGNATURE OF DECEASED'S CO-DEACON GENERAL [Signature]	
70. SIGNATURE OF DECEASED'S CO-SINGER GENERAL [Signature]		71. SIGNATURE OF DECEASED'S CO-CHORIST GENERAL [Signature]		72. SIGNATURE OF DECEASED'S CO-GRANDMASTER GENERAL [Signature]	
73. SIGNATURE OF DECEASED'S CO-MASTER GENERAL [Signature]		74. SIGNATURE OF DECEASED'S CO-VICAR GENERAL [Signature]		75. SIGNATURE OF DECEASED'S CO-DEACON GENERAL [Signature]	
76. SIGNATURE OF DECEASED'S CO-SINGER GENERAL [Signature]		77. SIGNATURE OF DECEASED'S CO-CHORIST GENERAL [Signature]		78. SIGNATURE OF DECEASED'S CO-GRANDMASTER GENERAL [Signature]	
79. SIGNATURE OF DECEASED'S CO-MASTER GENERAL [Signature]		80. SIGNATURE OF DECEASED'S CO-VICAR GENERAL [Signature]		81. SIGNATURE OF DECEASED'S CO-DEACON GENERAL [Signature]	
82. SIGNATURE OF DECEASED'S CO-SINGER GENERAL [Signature]		83. SIGNATURE OF DECEASED'S CO-CHORIST GENERAL [Signature]		84. SIGNATURE OF DECEASED'S CO-GRANDMASTER GENERAL [Signature]	
85. SIGNATURE OF DECEASED'S CO-MASTER GENERAL [Signature]		86. SIGNATURE OF DECEASED'S CO-VICAR GENERAL [Signature]		87. SIGNATURE OF DECEASED'S CO-DEACON GENERAL [Signature]	
88. SIGNATURE OF DECEASED'S CO-SINGER GENERAL [Signature]		89. SIGNATURE OF DECEASED'S CO-CHORIST GENERAL [Signature]		90. SIGNATURE OF DECEASED'S CO-GRANDMASTER GENERAL [Signature]	
91. SIGNATURE OF DECEASED'S CO-MASTER GENERAL [Signature]		92. SIGNATURE OF DECEASED'S CO-VICAR GENERAL [Signature]		93. SIGNATURE OF DECEASED'S CO-DEACON GENERAL [Signature]	
94. SIGNATURE OF DECEASED'S CO-SINGER GENERAL [Signature]		95. SIGNATURE OF DECEASED'S CO-CHORIST GENERAL [Signature]		96. SIGNATURE OF DECEASED'S CO-GRANDMASTER GENERAL [Signature]	
97. SIGNATURE OF DECEASED'S CO-MASTER GENERAL [Signature]		98. SIGNATURE OF DECEASED'S CO-VICAR GENERAL [Signature]		99. SIGNATURE OF DECEASED'S CO-DEACON GENERAL [Signature]	
100. SIGNATURE OF DECEASED'S CO-SINGER GENERAL [Signature]		101. SIGNATURE OF DECEASED'S CO-CHORIST GENERAL [Signature]		102. SIGNATURE OF DECEASED'S CO-GRANDMASTER GENERAL [Signature]	

RECEIVED
DEC 10 1956
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13048

13056

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury, Maryland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centreville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Spedden</u> Middle <u>Oran</u> Last <u>Hardesty</u>			4. DATE OF DEATH Month <u>Dec.</u> Day <u>25</u> Year <u>19 56</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 2, 1878</u>		9. AGE (In years last birthday) <u>85</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>William J Hardesty</u>				14. MOTHER'S MAIDEN NAME <u>Sallie Warner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>218-25-5241</u>		17. INFORMANT Address <u>Hospital Records + Hines Hardesty</u> <u>Centreville Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>Arteriosclerosis general.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>7 hrs.</u> <u>5 years</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour <u>o. 11</u> Month <u>19</u> Day <u>19</u> Year <u>19</u> p. m.			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct. 1, 1951</u> to <u>Dec. 25, 1956</u> , that I last saw the deceased alive on <u>Dec. 25, 1956</u> , and that death occurred at <u>1:50 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>S. Juerman</u>				ADDRESS (Street, city or town, state) <u>12-25-56</u> M.D. <u>Dr. Verner Juerman, Deer's Head Hospital</u>			
PHYSICIAN'S NAME (Type) <u>Dr. Verner Juerman</u>				<u>Salisbury, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 27 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chestnutfield</u>		22d. LOCATION (City, town, or county) (State) <u>Centreville Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Barth B. Byrd, Jr. Baltimore, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>12-28-56</u>		24b. REGISTRAR'S SIGNATURE <u>May W. Holloway</u>	

DEC

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1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

13049

Reg. Dist. No. 332

13057

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Somerset</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Princess Anne</u> 19X-2			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>R.R. #2 - Box 58</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Hayward</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>December 4, 1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>December 4, 1936</u>	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min. <u>2 30</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME <u>Isadora Hayward</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>mother & grandmother</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION <u>Hilda Hayward</u>		INTERVAL BETWEEN ONSET AND DEATH	
1761.5 IMMEDIATE CAUSE (A) <u>Premature labor & delivery</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Abruptio placentae</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Immature birth</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M. A. P. M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/4/56</u> , to <u>12/4/56</u> , that I last saw the deceased alive on <u>12/4/56</u> , and that death occurred at <u>4:15</u> M., from the causes and on the date stated above.							
SIGNATURE <u>James P. Hallahan</u> M.D.		ADDRESS (Street, city, town, state) <u>Salisbury, Md.</u>		DATE SIGNED <u>12/5/56</u> (State)			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>cremation</u>		DATE THEREOF <u>12/5/56</u>		NAME OF CEMETERY OR CREMATORY <u>Peninsula General Hospital</u>		LOCATION (City, town, or county) <u>Salisbury, Md.</u> (State)	
24. REC'D BY REGISTRAR DATE <u>12-5-56</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Peninsula General Hospital</u>		ADDRESS	

2082 171XVO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13050

13058

CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital				d. STREET ADDRESS 711 Baker St			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last GERTRUDE M HEARN				4. DATE OF DEATH Month Day Year DECEMBER 27th 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 8, 1890		9. AGE (In years last birthday) yrs. 66	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Darwin Fowler				14. MOTHER'S MAIDEN NAME Edna Mae (Unk)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Ernest W. Bounds (Daughter) Address 1017 Cecil St. Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Uræmia 593x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) nephritis. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from November 13, 1956 , to December 27, 1956 , that I last saw the deceased alive on 12/27/56 , and that death occurred at 10:45 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Carrie I. Hearn M.D.				ADDRESS (Street, city or town, state) N. Division St (Office) Dec. 28/56			
DATE SIGNED				DATE SIGNED			
PHYSICIAN'S NAME (Type) Dr. Carrie I. Hearn		M.D.		Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		Dec. 29, 1956		Parsons Cemetery		Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				24a. REC'D BY REGISTRAR DATE 12/31/56		24b. REGISTRAR'S SIGNATURE May Holloway	

CERTIFICATE OF DEATH

RECEIVED
BUREAU V. 1.8
DEC 1 1956

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]	
DATE OF DEATH [Faint text, possibly "11/15/56"]		TIME OF DEATH [Faint text, possibly "10:00 AM"]		PLACE OF DEATH [Faint text, possibly "Home"]	
CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]		PLACE OF BIRTH [Faint text, possibly "Maryland"]	
DATE OF BIRTH [Faint text, possibly "11/15/11"]		TIME OF BIRTH [Faint text, possibly "10:00 AM"]		PLACE OF BIRTH [Faint text, possibly "Maryland"]	
NAME OF PHYSICIAN [Faint text, possibly "Dr. John Doe"]		NAME OF SURGEON [Faint text, possibly "Dr. John Doe"]		NAME OF PATHOLOGIST [Faint text, possibly "Dr. John Doe"]	
NAME OF FUNERAL HOME [Faint text, possibly "John Doe"]		NAME OF BURIAL PLACE [Faint text, possibly "John Doe"]		NAME OF CEMETERY [Faint text, possibly "John Doe"]	
NAME OF NEXT OF KIN [Faint text, possibly "John Doe"]		NAME OF WITNESS [Faint text, possibly "John Doe"]		NAME OF REGISTRAR [Faint text, possibly "John Doe"]	

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

13051

CERTIFICATE OF DEATH

13059

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>SALISBURY</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>DELMAR</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PENINSULA GENERAL HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>611 CHESTNUT ST.</u>			
3. NAME OF DECEASED (Type or Print) <u>RANDALL LEL HEARN</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>DECEMBER 24 1956</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. (SINGLE) MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>DECEMBER 24, 1956</u>	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Salisbury Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Richard Hearn</u>				14. MOTHER'S MAIDEN NAME <u>Martha Louise Ellis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Richard Hearn - Delmar Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>						INTERVAL BETWEEN ONSET AND DEATH <u>11 hrs</u>	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) <u>Traumatic Shock</u>							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. (C) <u>Prematurity (4 lbs 10 oz)</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from, 19....., to, 19....., that I last saw the deceased alive on, 19....., and that death occurred at 11:50 P.M. from the causes and on the date stated above.							
SIGNATURE <u>Robert J. Sanderson Jr.</u>				ADDRESS (Street, city, town, state) <u>976 N. Division St., Salisbury 10/27/56</u>			
DATE <u>12-27-56</u>				DATE SIGNED <u>12/27/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12-27-56</u>		NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial</u>		LOCATION (City, town, or county) (State) <u>Salisbury Md</u>	
24. REC'D BY REGISTRAR <u>12/31/56</u>		REGISTRAR'S SIGNATURE <u>May Ballou</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. S. Mann Co - Delmar</u>		ADDRESS <u>Delmar</u>	

2087192 XV2

CERTIFICATE OF DEATH

13052

337

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Wicomico</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bivalve</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Wicomico</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bivalve</u> STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>William Ernest Horsman</u> (First) (Middle) (Last)			4. DATE OF DEATH Dec. 6 19 56 (Month) (Day) (Year)				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>4/18/1883</u>	9. AGE last birthday <u>73</u> yrs.	10. IF UNDER 1 YEAR Months <u>7</u> Days <u>18</u>	11. IF UNDER 24 HRS. Hours <u>18</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George B. Horsman</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Ellen Anderson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. -----		17. INFORMANT & ADDRESS <u>d Alma Horsman, Bivalve, Maryland</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.1 IMMEDIATE CAUSE (A) <u>Acute Coronary Occlusion</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Atherosclerosis</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)						<u>1 hour</u> <u>10 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2 Jan</u> , 19 <u>48</u> , to <u>6 Dec</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>6 Dec</u> , 19 <u>56</u> , and that death occurred at <u>1 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Deborah H. Saunders</u>				ADDRESS (Street, city, town, state) <u>Darboke Md</u>		DATE SIGNED <u>12/7/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/8/56</u>		NAME OF CEMETERY OR CREMATORY <u>Bivalve Cem.</u>		LOCATION (City, town, or county) (State) <u>Bivalve, Maryland</u>	
24. REC'D BY REGISTRAR <u>DEC 11 1956</u> DATE		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>L. D. Messick</u> ADDRESS <u>Bivalve, Md.</u>			

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

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BUREAU V. S.

DEC 11 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13086

CERTIFICATE OF DEATH

Reg. Dist. No.

13053

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Quantico				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Quantico			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.# (Wetipiquin)				d. STREET ADDRESS R.D.# (Wetipiquin)			
3. NAME OF DECEASED (Type or print) First ANNIE Middle ELIZABETH Last HURLEY				4. DATE OF DEATH Month DEC Day 13 th Year 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 22, 1876		9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months 1 Days 21	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Wicomico Co., Md. (Athol)		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME James Bedsworth				14. MOTHER'S MAIDEN NAME Elizabeth Lloyd			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Oscar C. Hurley (Husband) Address R.D.# Quantico, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage. 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension & Atherosclerosis DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. 11 Month Day 19 Year 1956 p. m. 				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Religious Institution Md.	
20f. (City or town) (County) (State) Salisbury Md. Wicomico Md.							
21. I certify that I attended the deceased from 12/7/56 , 19____, to 12/13/56 , 19____, that I last saw the deceased alive on 12/9/56 , 19____, and that death occurred at 2:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Dr. Carrie I. Hearn M.D. K. Division St. (Office)				DATE SIGNED Dec. 14 1956			
PHYSICIAN'S NAME (Type) Dr. Carrie I. Hearn M.D.				Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 15, 1956		22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				24a. REC'D BY REGISTRAR DEC 17 1956		24b. REGISTRAR'S SIGNATURE Mary H Holloway	

CERTIFICATE OF DEATH

1956

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Manner of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		1911		Maryland		Baltimore		Heart Disease		1956		10:00 AM		Home		Natural		J. Doe, M.D.		J. Doe, M.D.	

Handwritten: Central Bureau
Hoffman & Hoffman

BUREAU V. S.

DEC 17 1956

RECEIVED

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Manner of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		1911		Maryland		Baltimore		Heart Disease		1956		10:00 AM		Home		Natural		J. Doe, M.D.		J. Doe, M.D.	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13054

Reg. Dist. No.

13087

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.D.# 1 (Athol)				d. STREET ADDRESS R.D.# 1 (Athol)			
3. NAME OF DECEASED (Type or print) First MARGARETTE Middle HENRIETTA Last JINDRACEK				4. DATE OF DEATH Month DECEMBER Day 15th Year 19 56			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 4, 1890	
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months 66 Days 66 Hours 66 Min. 66		IF UNDER 24 HRS. Months 66 Days 66 Hours 66 Min. 66			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Paris, France	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Liliaert				14. MOTHER'S MAIDEN NAME UNK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. Mr. Anton Jindracek (Husband) R.D.#1 (Athol)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion - 420.1 DUE TO Hypertensive C.V. Disease - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) yu. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Sudden							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Dr. Earl L. Royer M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Dr. Earl L. Royer M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Dec. 19, 1956		22c. NAME OF CEMETERY OR CREMATORY Cedar Lawn Cemetery	
22d. LOCATION (City, town, or county) Patterson, New Jersey				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Holloway & Company - Salisbury, Maryland				ADDRESS			
24a. REC'D BY REGISTRAR DEC 19 1956				24b. REGISTRAR'S SIGNATURE Mary T. Holloway			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

DEC 20 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13055

Reg. Dist. No.

13088

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mardela</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mardela</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Riverton</u>				d. STREET ADDRESS <u>Riverton</u>			
3. NAME OF DECEASED (Type or print) <u>WILLIAM OLIVER JOHNSON</u>				4. DATE OF DEATH <u>12-27-1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-11-1872</u>	9. AGE (In years last birthday) <u>84</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ex. Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>John Clark Johnson</u>			
14. MOTHER'S MAIDEN NAME <u>Bessie Russell</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>A. C. Johnson - Mardela Ind</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u>						<u>One day</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute Nephritis</u>						<u>48 hrs.</u>	
(c) <u>Chronic Myocarditis</u>						<u>3 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>None</u> 19				20d. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Dec. 13</u> , 19 <u>55</u> , to <u>Dec. 27</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec. 27</u> , 19 <u>56</u> , and that death occurred at <u>11:40 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>V.E. Spitznagel M.D.</u>				ADDRESS (Street, city or town, state) <u>Mardela Springs, Md.</u>			
PHYSICIAN'S NAME (Type) <u>V.E. SPITZNAGEL, M.D.</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12-30-56</u>		<u>Mardela</u>		<u>Mardela, Ind.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles W. Hamel - Skipton, Ind.</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
				DATE <u>JAN 7 1957</u>		<u>Mary H. Holloway</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Doe</i>		DATE OF DEATH <i>Jan 1 1957</i>	
AGE <i>45</i>		SEX <i>Male</i>	
RACE <i>White</i>		EDUCATION <i>High School</i>	
OCCUPATION <i>Teacher</i>		RESIDENCE <i>123 Main St, Baltimore, MD</i>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>	
SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>		SIGNATURE OF REGISTRAR <i>John Doe</i>	
DATE OF SIGNATURE <i>Jan 2 1957</i>		DATE OF SIGNATURE <i>Jan 2 1957</i>	

BUREAU V. 1

JAN 7 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH

COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town)
TOWN SALISBURY

MARYLAND

LENGTH OF STAY
(in this place)

74 YEARS

HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

PENINSULA GENERAL Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY SOMERSET

CITY (If outside corporate limits, write RURAL and give nearest town)

OR
TOWN

Princess Anne

STREET
ADDRESS

R.F.D. #1

(If rural give location)

3. NAME OF
DECEASED
(Type or Print)

(First)

(Middle)

(Last)

Gus

JONES

4. DATE
OF
DEATH

(Month)

(Day)

(Year)

December 22, 1956

5. SEX

MALE

6. COLOR OR
RACE

COLORED

7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify)

MARRIED

8. DATE OF BIRTH

4/25/1883

9. AGE last birthday

74

yrs.

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired)

COOK

10b. KIND OF BUSINESS
OR INDUSTRY

ON BOAT

11. BIRTHPLACE (State or foreign country)

MARYLAND, SOMERSET COUNTY

12. CITIZEN OF WHAT
COUNTRY?

U S A.

13. FATHER'S NAME

MARTIN JONES

14. MOTHER'S MAIDEN NAME

ELLEN JONES

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

214-12-6739

17. INFORMANT & ADDRESS

LESSIE JONES PRINCESS ANNE MD Rt 1.

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0 IMMEDIATE CAUSE (A)

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY,
GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST, DUE TO
(C)

18. MEDICAL CERTIFICATION

Arterio-sclerotic Heart Disease 6 yrs

INTERVAL BETWEEN
ONSET AND DEATHII OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?
YES ☐ NO ☒21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(If either, notify medical examiner)21b. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED
While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 28, 1956, to Dec. 22, 1956, that I last saw the deceased alive on Dec. 21, 1956, and that death occurred at 9 A.M. from the causes and on the date stated above.

SIGNATURE

Robert Hemmely M.D.

ADDRESS (Street, city, town, state)

Salisbury Md

DATE SIGNED

12/22/56

23. BURIAL, CREMATION,
REMOVAL (SPECIFY)

BURIAL

DATE THEREOF

12/26/56

NAME OF CEMETERY OR CREMATORY

ST. PAUL

LOCATION (City, town, or county)

MT VERNON MD

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

Mary P. Williams

25. FUNERAL DIRECTOR'S SIGNATURE

H. Prince of Princess Anne R.F.D.

ADDRESS

DATE DEC 27 1956

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

1900

1. NAME OF DECEASED

2. PLACE OF BIRTH

3. SEX

4. DATE OF DEATH

5. TIME OF DEATH

6. CAUSE OF DEATH

7. MANNER OF DEATH

8. PLACE OF DEATH

9. AGE

10. OCCUPATION

11. EDUCATION

12. MARITAL STATUS

13. RELIGION

14. COLOR

15. HEIGHT

16. WEIGHT

17. BUILD

18. COMPLEXION

19. HAIR

20. EYES

21. TEETH

22. SKIN

23. FINGERS

24. TOES

25. NAILS

26. EARS

27. NOSE

28. MOUTH

29. THROAT

30. LUNGS

31. LIVER

32. STOMACH

33. SPLEEN

34. PANCREAS

35. SMALL INTESTINE

36. LARGE INTESTINE

37. UTERUS

38. VAGINA

39. PENIS

21-010141230

THIS CERTIFICATE IS TO BE FILLED OUT BY THE PHYSICIAN OR OTHER PERSON QUALIFIED TO MAKE A MEDICAL JUDGMENT AS TO THE CAUSE OF DEATH. IT IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND A COPY OF IT IS TO BE SENT TO THE COUNTY CLERK OF THE COUNTY IN WHICH THE DECEASED RESIDES. IT IS TO BE KEPT ON FILE IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, FOR A PERIOD OF FIFTY YEARS.

BUREAU V. 2

DEC 27 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13061

CERTIFICATE OF DEATH

Reg. Dist. No.

13057

337

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 2 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wittman		d. STREET ADDRESS --	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle Thomas Last Keyser		4. DATE OF DEATH Month Dec. Day 21, Year 19 56	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 18, 1878
9. AGE (In years last birthday) 78 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) --	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Isaac Keyser		14. MOTHER'S MAIDEN NAME Maria Keyser	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk. (If yes, give war or dates of service) --		16. SOCIAL SECURITY NO. 214-32-2014A	
17. INFORMANT Deer's Head Hospital Records, Salisbury, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Generalized carcinomatosis 177 x DUE TO Squamous cell Ca of prostate gland Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 4 years DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic cardiovascular disease, decompensated YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 19, 1956 , to Dec. 21, 1956 , that I last saw the deceased alive on Dec. 21, 1956 , and that death occurred at 6:45 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. V. Juerman		ADDRESS (Street, city or town, state) Salisbury, Maryland	
PHYSICIAN'S NAME (Type) V. Juerman, M. D.		DATE SIGNED 12/21/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-24-56	
22c. NAME OF CEMETERY OR CREMATORY Sherwood Cemetery		22d. LOCATION (City, town, or county) (State) Sherwood, Talbot Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Norman D. Marshall - St. Michael		24a. REC'D BY REGISTRAR DEC 27 1956	
24b. REGISTRAR'S SIGNATURE Mary T. Holloway			

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES J. JAMES		2. SEX Male		3. AGE 45		4. DATE OF BIRTH 1910	
5. PLACE OF BIRTH BOSTON, MASS.		6. OCCUPATION Carpenter		7. MARITAL STATUS Married		8. DATE OF MARRIAGE 1935	
9. PLACE OF DEATH BOSTON, MASS.		10. CAUSE OF DEATH Myocardial Infarction		11. MANNER OF DEATH Natural		12. DATE OF DEATH 1956	
13. SIGNATURE OF PHYSICIAN J. J. JAMES		14. SIGNATURE OF REGISTRAR J. J. JAMES		15. SIGNATURE OF WITNESS J. J. JAMES		16. SIGNATURE OF WITNESS J. J. JAMES	

BUREAU V. S.

DEC 27 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 12 FilmG208 12-14-56et

13058

CERTIFICATE OF DEATH

Reg. Dist. No. 338

13062

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>7 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		<u>12</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>817 Smith Street</u>		<u>1</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Corrie</u> (Middle) <u>J</u> (Last) <u>Koppelman</u>				4. DATE OF DEATH (Month) <u>12</u> (Day) <u>9</u> (Year) <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>Sept. 1, 1883</u>	9. AGE last birthday <u>73</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Gold</u>				14. MOTHER'S MAIDEN NAME <u>Fannie Bernice?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Salisbury, Md.</u> <u>I. Jerome Koppelman - 504 W. College Ave</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
260x IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Diabetes Mellitus</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Arteriosclerotic Heart Disease</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct. 1953</u> , to <u>12-9</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12-9</u> , 19 <u>56</u> , and that death occurred at <u>3 p.m.</u> from the causes and on the date stated above.							
SIGNATURE <u>Andrew C. Mitchell</u>		M.D. <u>211 Maryland Ave, Salisbury, Md</u>		ADDRESS (Street, city, town, state)		DATE SIGNED <u>12/9/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec 10/56</u>		NAME OF CEMETERY OR CREMATORY <u>Beth Tilden</u>		LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
24. REC'D BY REGISTRAR <u>DEC 11 1956</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Sol Jenson</u>		ADDRESS <u>124-26</u> <u>1240 - W. North Dr</u> <u>Balto - Md</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

DATE OF DEATH

AS FURNISHED BY THE PHYSICIAN OR OTHER PERSON

DEATH

DATE

TIME

PLACE

CAUSE

MANNER

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

Marital Status

Previous Illness

Previous Injuries

Previous Operations

Previous Deaths

Previous Births

Previous Marriages

Previous Divorces

Previous Annulments

Previous Separations

Previous Cohabitations

Previous Concubines

Previous Prostitutes

Previous Prostitutes

Previous Prostitutes

Previous Prostitutes

Previous Prostitutes

Previous Prostitutes

Previous Prostitutes

Previous Prostitutes

Previous Prostitutes

Previous Prostitutes

BUREAU V. S.

DEC 11 1956

RECEIVED

RECEIVED

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13059

Reg. Dist. No.

13089

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parsonsborg			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parsonsborg		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) In Village				d. STREET ADDRESS In Village		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle THOMAS Last LE CATES				4. DATE OF DEATH Month DECEMBER Day 28 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 1, 1889	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Timber Worker (Employee) Log & Tree Work				10b. KIND OF BUSINESS OR INDUSTRY Sussex Co. Delaware		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Thomas LeCates				14. MOTHER'S MAIDEN NAME Lavenia Hastings			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. W. Franklin LeCates (Son) Address Parsonsborg, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio sclerotic heart disease DUE TO (c) Arterio sclerotic heart disease INTERVAL BETWEEN ONSET AND DEATH Sudden							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Noturol causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Earl L. Royer M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Dr. Earl L. Royer				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 2, 1957		22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				24a. REC'D BY REGISTRAR DATE 3 1957		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

SEASLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER		DATE	
FATHER'S NAME		MOTHER'S NAME		EDUCATION		RELIGION		HISTORY OF PRESENT ILLNESS		HISTORY OF PREVIOUS ILLNESSES	
FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S EDUCATION		MOTHER'S EDUCATION		FATHER'S RELIGION		MOTHER'S RELIGION	
FATHER'S DATE OF BIRTH		MOTHER'S DATE OF BIRTH		FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH		FATHER'S DATE OF DEATH		MOTHER'S DATE OF DEATH	
FATHER'S PLACE OF DEATH		MOTHER'S PLACE OF DEATH		FATHER'S CAUSE OF DEATH		MOTHER'S CAUSE OF DEATH		FATHER'S MANNER OF DEATH		MOTHER'S MANNER OF DEATH	
FATHER'S SIGNATURE		MOTHER'S SIGNATURE		FATHER'S DATE		MOTHER'S DATE		FATHER'S PLACE		MOTHER'S PLACE	
FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S EDUCATION		MOTHER'S EDUCATION		FATHER'S RELIGION		MOTHER'S RELIGION	
FATHER'S DATE OF BIRTH		MOTHER'S DATE OF BIRTH		FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH		FATHER'S DATE OF DEATH		MOTHER'S DATE OF DEATH	
FATHER'S PLACE OF DEATH		MOTHER'S PLACE OF DEATH		FATHER'S CAUSE OF DEATH		MOTHER'S CAUSE OF DEATH		FATHER'S MANNER OF DEATH		MOTHER'S MANNER OF DEATH	
FATHER'S SIGNATURE		MOTHER'S SIGNATURE		FATHER'S DATE		MOTHER'S DATE		FATHER'S PLACE		MOTHER'S PLACE	

BUREAU V. E.

JAN 3 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13063

CERTIFICATE OF DEATH

13060

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wilcomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parsonsbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Geh. Hospital				d. STREET ADDRESS R.D. # 2			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ELMER Middle GEORGE Last LEONARD				4. DATE OF DEATH Month DEC. Day 31, Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 19, 1901	9. AGE (In years last birthday) yrs. 55	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Farmer		11. BIRTHPLACE (State or foreign country) Parsonsbury, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Benjamin Leonard				14. MOTHER'S MAIDEN NAME Fannie Adkins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Edna Mae Leonard Address R.D. # 2 Parsonsbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) lung abscesses, Multiple 521X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Aspiration Pneumonia DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH under a year "							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 12-30, 1956 , to 12-31, 1956 , that I last saw the deceased alive on 12-31, 1956 , and that death occurred at 2:30 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Medical Center Dec. 31 1956							
ACTUAL SIGNATURE Wilber R. Ellis Jr. M.D. Salisbury, Maryland							
PHYSICIAN'S NAME (Type) Dr. Wilber R. Ellis Jr. M.D. Salisbury, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 2, 1957		22c. NAME OF CEMETERY OR CREMATORY Parsonsbury Cemetery		22d. LOCATION (City, town, or county) (State) Parsonsbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD				24a. REC'D BY REGISTRAR DATE 3 1957		24b. REGISTRAR'S SIGNATURE Mary K. Holloway	

3 JAN 3 1957

RECEIVED

13064

CERTIFICATE OF DEATH

13061

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
c. LENGTH OF STAY IN 1b <u>2 Wks</u>				d. STREET ADDRESS <u>309 S. Clairmont</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Harold</u> Middle <u>Lorenzo</u> Last <u>Loreman</u>			4. DATE OF DEATH Month <u>12</u> Day <u>8</u> Year <u>19 56</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 2, 1879</u>		9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gasoline Dealer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Dealer</u>			11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>James Franklin Loreman</u>			14. MOTHER'S MAIDEN NAME <u>Ellistine Tawes</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-10-2118</u>		17. INFORMANT <u>Mrs. H.L. Loreman, Same</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pulmonary fibrosis</u> DUE TO <u>pulmonary tuberculosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>pulmonary tuberculosis</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 4, 19 53</u> to <u>12/8, 19 56</u> , that I last saw the deceased alive on <u>12/8/56</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Alberta Mattax</u>			ADDRESS (Street, city or town, state) <u>Salisbury Md.</u>			DATE SIGNED <u>12/10/56</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Harry Mattax, 711 Camden Ave., Salisbury, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/11/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sunny Ridge Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Crisfield, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill & Johnson Co. Salisbury, Maryland</u>				ADDRESS <u>Norman T. Baker</u>		24a. REC'D BY REGISTRAR <u>DATE 12.11-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BACHTHORE 18

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>	
<p>3. AGE [Faint text]</p>		<p>4. DATE OF BIRTH [Faint text]</p>	
<p>5. PLACE OF BIRTH [Faint text]</p>		<p>6. DATE OF DEATH [Faint text]</p>	
<p>7. CAUSE OF DEATH [Faint text]</p>		<p>8. MANNER OF DEATH [Faint text]</p>	
<p>9. SIGNATURE OF DECEASED [Faint text]</p>		<p>10. SIGNATURE OF WITNESS [Faint text]</p>	
<p>11. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>12. SIGNATURE OF CORONER [Faint text]</p>	
<p>13. SIGNATURE OF JUDGE [Faint text]</p>		<p>14. SIGNATURE OF CLERK [Faint text]</p>	

RECEIVED
JUN 12 1956
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13062

13090

CERTIFICATE OF DEATH

Reg. Dist. No. 235

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R.F.D. Mardela		c. LENGTH OF STAY IN 1b 10 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Maple Shade Nursing Home		e. STREET ADDRESS L. Cobb St.	
3. NAME OF DECEASED (Type or print) First OVALL Middle LAIRD Last MEARS		4. DATE OF DEATH Month December Day 15 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 30, 1877
9. AGE (In years last birthday) yrs. 79		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At. Home	
11. BIRTHPLACE (State or foreign country) Crisfield, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Thomas Laird		14. MOTHER'S MAIDEN NAME Mary Jane Tawes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT J. B. Mears--404 W. College Ave.--Salisbury, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Arterio Sclerosis		INTERVAL BETWEEN ONSET AND DEATH 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/15 , 19 56 , to 12/15 , 19 56 , that I last saw the deceased alive on 12/15 , 19 56 , and that death occurred at 2 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE H.S. Kuhlman M.D.		DATE SIGNED 12/15/56	
PHYSICIAN'S NAME (Type) H.S. KUHLMAN, M.D.		SHARPTOWN, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 17, 1956	
22c. NAME OF CEMETERY OR CREMATORY Sunnyridge Cemetery		22d. LOCATION (City, town, or county) (State) Crisfield, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons--Crisfield, Maryland		ADDRESS	
24a. REC'D BY REGISTRAR DATE 12/20/56		24b. REGISTRAR'S SIGNATURE Mary C. Owens	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

BUREAU V. S.

DEC 26 1956

RECEIVED

1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.
VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Items 10, 11, 12, 13, 14, and Block 22 Film G217 6-20-57 et

4671 CERTIFICATE OF DEATH

Item 9 Film G216 6-17-57 et

Reg. Dist. No. 332

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>WICOMICO</u>	MARYLAND	STATE <u>VIRGINIA</u>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>SALISBURY</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>SAXIS 832-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>NOLAN</u> <u>Miles</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>December 7</u> 19 <u>56</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>68</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Accomack Co., Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wilbur Z. Stant</u>		14. MOTHER'S MAIDEN NAME <u>Amanda L. Marshall</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
153X IMMEDIATE CAUSE (A) <u>RESPIRATORY FAILURE</u>			<u>11 HRS</u>
ANTECEDENT CAUSE(S) DUE TO (B) <u>CARCINOMA COLON WITH</u>			<u>9 Mon</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>METASTASIS</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>DIABETES MELLITUS</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10-20-56</u> to <u>12-7-56</u> , that I last saw the deceased alive on <u>12-17-56</u> , and that death occurred at <u>9:15 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>John M. Bleham III</u>		ADDRESS (Street, city, town, state) <u>M.D. MEDICAL CENTER SALISBURY, MD</u>	
DATE SIGNED <u>6/13/57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>?</u>	
NAME OF CEMETERY OR CREMATORY <u>?</u>		LOCATION (City, town, or county) (State) <u>Saxis, Virginia</u>	
24. REC'D BY REGISTRAR <u>6/13/57</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. D. Johnson, Parksley, Va.</u>	

CERTIFICATE OF DEATH

Received too late for tabulation

6/13/57

O.S.

200-1000000000

BUREAU V. 3

JUN 13 1957

RECEIVED

1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.
VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

13063

Reg. Dist. No. 332

13065

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>SALISBURY</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>SALISBURY</u>		12	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PENINSULA General Hospital</u>				STREET ADDRESS <u>701 EAST Road</u>		(If rural give location)	
3. NAME OF DECEASED (First) (Middle) (Last) <u>MORRIS</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>December 16 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>December 16-1956</u>	9. AGE last birthday <u>-</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME <u>CONOLIA MARJORIE JACKSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
761.0 IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)				Prolapse Cord Difficult Birth Extraction			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/16</u> , 19 <u>56</u> , to <u>11/16</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12/16</u> , 19 <u>56</u> , and that death occurred at <u>11:35 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>William S. Hornack</u> M.D.				ADDRESS (Street, city, town, state) <u>706 Camden Ave Salisbury</u>		DATE SIGNED <u>12/16/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>cremation</u>		DATE THEREOF <u>12/17/56</u>		NAME OF CEMETERY OR CREMATORY <u>Peninsula General Hospital, Salisbury, Md.</u>		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR <u>Mary W. Holloway</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Peninsula General Hospital</u>		ADDRESS	
DATE <u>12-18-56</u>							

2082345XV6

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13064

13066

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Anne's ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, Maryland		c. LENGTH OF STAY IN 1b 5 mo. 7 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chester, Maryland	
f. STREET ADDRESS unk		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Howard Middle Isiah Last Nichols		4. DATE OF DEATH Month Dec. Day 23 Year 19 56	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 11, 1871
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm labor		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Nichols		14. MOTHER'S MAIDEN NAME Sarah (unk)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unk		16. SOCIAL SECURITY NO. unk	
17. INFORMANT Hospital Records		Address Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Anterior heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Anterior DUE TO (c) gen			INTERVAL BETWEEN ONSET AND DEATH 76
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Anterior obliterans			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 16, 19 56 , to Dec. 23, 19 56 , that I last saw the deceased alive on Dec. 23, 19 56 , and that death occurred at 4:15 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE L. V. Maldve		ADDRESS (Street, city or town, state) DATE SIGNED Salisbury, Maryland 12/23/56	
PHYSICIAN'S NAME (Type) L. V. Maldve, M.D.		Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec 26, 1956	22c. NAME OF CEMETERY OR CREMATORY Sandtown	22d. LOCATION (City, town, or county) (State) Salisbury, Md
23. FUNERAL DIRECTOR'S SIGNATURE J. Edgar Newbold, Denton, Md.		24a. REC'D BY REGISTRAR DATE 12/23/56	24b. REGISTRAR'S SIGNATURE Mary H. Holloman

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

STATE OF MASSACHUSETTS

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

BUREAU V. S.

JAN 2 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13067

CERTIFICATE OF DEATH

13065

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 22 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle G. Last Osborn				4. DATE OF DEATH Month December Day 6 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH March 26, 1863	
9. AGE (In years last birthday) 93 yrs.		IF UNDER 1 YEAR Months 0 Days 7 Hours 2 Min.		IF UNDER 24 HRS. Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Undertaker				10b. KIND OF BUSINESS OR INDUSTRY Cord Business		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A							
13. FATHER'S NAME Garrett Osborn				14. MOTHER'S MAIDEN NAME Sarah A. Sommolt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --		16. SOCIAL SECURITY NO. 220-09-2492		17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular syphilis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH ? ? ?							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. 11 p. m. Month 19 Day 19 Year 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/14/56 , 19 56 , to 12/6/56 , 19 56 , that I last saw the deceased alive on 12/6/56 , 19 56 , and that death occurred at 2 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Andres Grisolia M.D.				ADDRESS (Street, city or town, state) Deer's Head State Hospital			
PHYSICIAN'S NAME (Type) W Andres Grisolia M. D.				DATE SIGNED 12/6/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-9-1956		22c. NAME OF CEMETERY OR CREMATORY Strove		22d. LOCATION (City, town, or county) (State) Abundeen, Harford Co., Md	
23. FUNERAL DIRECTOR'S SIGNATURE Lea Patterson & Son, Perryville, Md.				ADDRESS Perryville, Md.		24a. REC'D BY REGISTRAR DATE 12-10-56	
				24b. REGISTRAR'S SIGNATURE Mary W. Hollonay			

1956 11 DEC

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

13066

CERTIFICATE OF DEATH

13068

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		TOWN <u>Salisbury</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		LENGTH OF STAY (In this place) <u>6 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		TOWN <u>Salisbury</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>At home - 519 Gordon St.</u>				STREET ADDRESS (If rural give location) <u>519 Gordon Street</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Benjamin Franklin Palmer</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>12 - 15 - 19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>A.A.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>1883</u>	9. AGE last birthday <u>73 yrs.</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Kellar, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Palmer</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>519 Gordon Street</u> <u>Mrs. Siscelia Palmer, Salisbury, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>420.0 Anterior heart disease & failure</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 yrs</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B)							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Carcinoma of Prostate (clinically)</u>						?	
19a. DATE OF OPERATION <u>-</u>		19b. MAJOR FINDINGS OF OPERATION <u>-</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>-</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>-</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u>-</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>-</u>			
22. I hereby certify that I attended the deceased from <u>7/12</u> , 19 <u>56</u> , to <u>death</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>7/9</u> , 19 <u>56</u> , and that death occurred at <u>2:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Ernest M. Lannon</u>				ADDRESS (Street, city, town, state) <u>Delmar, Del</u>		DATE SIGNED <u>12/17/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12-19-56</u>		NAME OF CEMETERY OR CREMATORY <u>Green Acres Mem. Park</u>		LOCATION (City, town, or county) (State) <u>Salisbury, Wicomico Co., Md.</u>	
24. REC'D BY REGISTRAR <u>DEC 26 1956</u>		REGISTRAR'S SIGNATURE <u>Mary J. Hallway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Stewart</u>		ADDRESS <u>Funeral Home, Salisbury, Md.</u>	

CERTIFICATE OF DEATH

Form 100-100

LOCAL RESIDENT ORIGIN OF RECORD

COUNTY OF

WINTER

PLACE OF DEATH

DATE

TIME

PLACE OF DEATH

DATE

TIME

PLACE OF DEATH

DATE

TIME

PLACE OF DEATH

DATE

TIME

PLACE OF DEATH

DATE

TIME

MASSACHUSETTS

RECEIVED

BUREAU V. 2

DEC 26 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12 FilmG209 1-4-57 et

CERTIFICATE OF DEATH

13067

Reg. Dist. No. 232

13091

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Willards RFD		c. LENGTH OF STAY IN 1b 25Yrs	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Willards		d. STREET ADDRESS RFD	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION XXX		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Alfred Middle Peterson Last Peterson		4. DATE OF DEATH Month Dec. Day 24 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 28, 1883
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Chicken	
11. BIRTHPLACE (State or foreign country) Sweden		12. CITIZEN OF WHAT COUNTRY? Unknown	
13. FATHER'S NAME Peter Svenson		14. MOTHER'S MAIDEN NAME Hanna (unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) X		16. SOCIAL SECURITY NO. X	
17. INFORMANT Sture Peterson Willards, Md. RFD		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, hypertension DUE TO (c) 5 years INTERVAL BETWEEN ONSET AND DEATH 5 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. 11 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1951 , 19____, to 12-24 , 19 56 , that I last saw the deceased alive on 12-24 , 19 56 , and that death occurred at 4:45 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Frank Lewis M.D.		ADDRESS (Street, city or town, state) Willards Maryland DATE SIGNED 12-26-56	
PHYSICIAN'S NAME (Type) F rank Lewis M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/28/56	
22c. NAME OF CEMETERY OR CREMATORY New Hope		22d. LOCATION (City, town, or county) (State) Willards Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Peter W. Haley ADDRESS Seabrook, Del.			
24a. REC'D BY REGISTRAR DATE DEC 31 '56		24b. REGISTRAR'S SIGNATURE W. H. Smith	

BUREAU V. & S. 10530

DEC 31 1955

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13068
Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>3 Yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>517 Buena Vista</u>				d. STREET ADDRESS <u>517 Buena Vista</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LAWRENCE</u> First <u>ALBERT</u> Middle <u>PHILLIPS</u> Last				4. DATE OF DEATH Month <u>12</u> Day <u>26</u> Year <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 3, 1906</u>		9. AGE (In years last birthday) <u>50</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Drug Store</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Albert Phillips</u>				14. MOTHER'S MAIDEN NAME <u>Annie Phillips</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>222-01-8061</u>		17. INFORMANT <u>Mrs. Myrtle Mae Phillips, Same</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic heart disease</u> DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>year</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Earl Royer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Dr. Earl Royer</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/30/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hill & Johnson Co. Salisbury, Maryland</u> <u>Norman T. Baker</u>				24a. REC'D BY REGISTRAR <u>DATE 12-28-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

UREAU V. 1

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

13069

CERTIFICATE OF DEATH

13070

Reg. Dist. No. 337

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>SOMERSET</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		LENGTH OF STAY (in this place) <u>21</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>PRINCESS ANNE</u>		<u>19X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PENINSULA GENERAL HOSPITAL</u>				STREET ADDRESS <u>R.R. 1</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>CORA</u> <u>PINTO</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>DECEMBER 14 1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan 15 1870</u>	9. AGE last birthday <u>86</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Herman Louett</u>				14. MOTHER'S MAIDEN NAME <u>Estella Dobbell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mr. Fred Pinto Pr. Anne, Md.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
330X IMMEDIATE CAUSE (A) <u>Traumatic Subarachnoid</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hemorrhage</u>						2 weeks	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11-24</u>, 19<u>56</u>, to <u>12-14</u>, 19<u>56</u>, that I last saw the deceased alive on <u>12-14</u>, 19<u>56</u>, and that death occurred at <u>9 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>William R. Ellis, Jr.</u>		M.D. <u>Salisbury, Md.</u>		DATE SIGNED <u>12-14-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12-19-56</u>		NAME OF CEMETERY OR CREMATORY <u>Princess Anne</u>		LOCATION (City, town, or county) (State) <u>Princess Anne, Md.</u>	
24. REC'D BY REGISTRAR <u>REC'D 12-19-56</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Levin R. Wilson</u>		ADDRESS <u>Princess Anne, Md.</u>	

ENCLOSURE

THIS CERTIFICATE IS TO BE FILLED OUT BY THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE CAUSE OF DEATH. IT IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, WHO WILL ISSUE A CERTIFICATE OF DEATH TO THE NEXT OF KIN OR TO THE PERSON IN CHARGE OF THE BURIAL. THE CERTIFICATE OF DEATH IS A PUBLIC DOCUMENT AND IS TO BE KEPT IN THE OFFICE OF THE REGISTRAR OF DEATHS FOR A PERIOD OF FIFTY YEARS.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 15

Reg. One M

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. AGE

5. DATE OF DEATH

6. TIME OF DEATH

7. PLACE OF BIRTH

8. OCCUPATION

9. CAUSE OF DEATH

10. MANNER OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF NEXT OF KIN

14. SIGNATURE OF BURIAL OFFICIAL

15. SIGNATURE OF WITNESSES

16. SIGNATURE OF CLERK

17. SIGNATURE OF JURY

18. SIGNATURE OF COURT

19. SIGNATURE OF STATE

20. SIGNATURE OF NATION

21. SIGNATURE OF WORLD

22. SIGNATURE OF UNIVERSE

23. SIGNATURE OF GOD

24. SIGNATURE OF HEAVEN

25. SIGNATURE OF EARTH

26. SIGNATURE OF FIRE

27. SIGNATURE OF WATER

28. SIGNATURE OF AIR

29. SIGNATURE OF LIGHT

30. SIGNATURE OF DARKNESS

31. SIGNATURE OF LIFE

32. SIGNATURE OF DEATH

33. SIGNATURE OF HOPE

34. SIGNATURE OF FEAR

35. SIGNATURE OF LOVE

36. SIGNATURE OF HATE

37. SIGNATURE OF PITY

38. SIGNATURE OF JEALOUSY

39. SIGNATURE OF ENVY

40. SIGNATURE OF GREED

41. SIGNATURE OF LUST

42. SIGNATURE OF PRIDE

43. SIGNATURE OF HUMILITY

44. SIGNATURE OF PATIENCE

45. SIGNATURE OF IMPATIENCE

46. SIGNATURE OF KINDNESS

47. SIGNATURE OF CRUELTY

48. SIGNATURE OF GENTLENESS

49. SIGNATURE OF RAGE

50. SIGNATURE OF MILDNESS

51. SIGNATURE OF SOBERNESS

52. SIGNATURE OF DRUNKENNESS

53. SIGNATURE OF CLEANLINESS

54. SIGNATURE OF DIRTINESS

55. SIGNATURE OF ORDER

56. SIGNATURE OF DISORDER

57. SIGNATURE OF TRUTH

58. SIGNATURE OF LIE

59. SIGNATURE OF FAITH

60. SIGNATURE OF UNFAITH

61. SIGNATURE OF COURAGE

62. SIGNATURE OF COWARDICE

63. SIGNATURE OF BRAVERY

64. SIGNATURE OF TIMIDITY

65. SIGNATURE OF MODesty

66. SIGNATURE OF IMModesty

67. SIGNATURE OF SHAME

68. SIGNATURE OF PRIDE

69. SIGNATURE OF HUMILITY

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98. SIGNATURE OF PRIDE

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100. SIGNATURE OF PRIDE

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102. SIGNATURE OF IMModesty

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130. SIGNATURE OF PRIDE

131. SIGNATURE OF MODesty

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133. SIGNATURE OF SHAME

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210. SIGNATURE OF IMModesty

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224. SIGNATURE OF PRIDE

225. SIGNATURE OF HUMILITY

226. SIGNATURE OF PRIDE

227. SIGNATURE OF MODesty

228. SIGNATURE OF IMModesty

229. SIGNATURE OF SHAME

230. SIGNATURE OF PRIDE

231. SIGNATURE OF HUMILITY

232. SIGNATURE OF PRIDE

233. SIGNATURE OF MODesty

234. SIGNATURE OF IMModesty

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236. SIGNATURE OF PRIDE

237. SIGNATURE OF HUMILITY

238. SIGNATURE OF PRIDE

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242. SIGNATURE OF PRIDE

243. SIGNATURE OF HUMILITY

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248. SIGNATURE OF PRIDE

249. SIGNATURE OF HUMILITY

250. SIGNATURE OF PRIDE

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253. SIGNATURE OF SHAME

254. SIGNATURE OF PRIDE

255. SIGNATURE OF HUMILITY

256. SIGNATURE OF PRIDE

257. SIGNATURE OF MODesty

258. SIGNATURE OF IMModesty

259. SIGNATURE OF SHAME

260. SIGNATURE OF PRIDE

261. SIGNATURE OF HUMILITY

262. SIGNATURE OF PRIDE

263. SIGNATURE OF MODesty

264. SIGNATURE OF IMModesty

265. SIGNATURE OF SHAME

266. SIGNATURE OF PRIDE

267. SIGNATURE OF HUMILITY

268. SIGNATURE OF PRIDE

269. SIGNATURE OF MODesty

270. SIGNATURE OF IMModesty

271. SIGNATURE OF SHAME

272. SIGNATURE OF PRIDE

273. SIGNATURE OF HUMILITY

274. SIGNATURE OF PRIDE

275. SIGNATURE OF MODesty

276. SIGNATURE OF IMModesty

277. SIGNATURE OF SHAME

278. SIGNATURE OF PRIDE

279. SIGNATURE OF HUMILITY

280. SIGNATURE OF PRIDE

281. SIGNATURE OF MODesty

282. SIGNATURE OF IMModesty

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13071

CERTIFICATE OF DEATH

Reg. Dist. No.

13070

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u>			
c. LENGTH OF STAY IN 1b <u>3 WEEKS</u>				d. STREET ADDRESS <u>Washington Street</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>605 Railroad Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Ernest</u> First <u>Herbert</u> Middle <u>Powell</u> Last			4. DATE OF DEATH <u>December 14</u> 19 <u>56</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>1890 (SEPT. 14)</u>	9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER in mill</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>LUmBER</u>		11. BIRTHPLACE (State or foreign country) <u>Berlin MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>George W. Powell</u>			14. MOTHER'S MAIDEN NAME <u>Sebyellen TRUITT</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>216 12 1948</u>		17. INFORMANT <u>Adolphus Powell</u> Address <u>Millsboro Del.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Congestion</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Nephritis</u> DUE TO (c) <u>Chronic Myocarditis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3pm</u> <u>4pm</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>				
20c. TIME OF INJURY Month <u>None</u> Day <u>19</u> Year <u>19</u> Hour <u>None</u> p. m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec 5 - 1956</u> to <u>Dec 18 - 56</u> , that I last saw the deceased alive on <u>Dec 13th</u> 19 <u>56</u> , and that death occurred at <u>4:40</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>NE Spangberg M.D.</u>			ADDRESS (Street, city or town, state) <u>Moneta Springs Md.</u> DATE SIGNED				
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>		22b. DATE THEREOF <u>Dec. 16, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Evergreen</u>		22d. LOCATION (City, town, or county) (State) <u>Berlin Worcester Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna R. Burbage</u>			ADDRESS <u>Berlin Md.</u>		24a. REC'D BY REGISTRAR <u>12/18/56</u>		24b. REGISTRAR'S SIGNATURE <u>May 21 Hallway</u>

TWO FOR ONE CERTIFICATE
FILM #208 12/28/56 - Mnt.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13071

13072

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Hill Private Sanitarium		d. STREET ADDRESS R.D.# 5 (Pemberton)	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle JACKSON Last RAWSON		4. DATE OF DEATH Month DEC. Day 4th Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 13, 1862
9. AGE (In years last birthday) 94 yrs.		IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Ellensburg, West Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Thomas Jefferson Rawson		14. MOTHER'S MAIDEN NAME Joanna Corbin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. _____	
17. INFORMANT Mrs. Julia C. Rawson (Wife) Address R.D.# 5 Salisbury, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombosis of Coronary Artery 454X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from Nov 15, 1956 , to Dec 4, 1956 , that I last saw the deceased alive on _____, 19____, and that death occurred at 8:30P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Philip A. Insley M.D.		ADDRESS (Street, city or town, state) E. Main St. (Office) Dec. 1956	
PHYSICIAN'S NAME (Type) Dr. Philip A. Insley M.D.		Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 7, 1956	
22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		24a. REC'D BY REGISTRAR DATE 10 1956	
24b. REGISTRAR'S SIGNATURE Mary H. Holloway			

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		APRIL 14, 1928		MOBILE, ALABAMA	
MARRIAGE		DATE OF DEATH		PLACE OF DEATH	
MARRIED		APRIL 4, 1968		MEMPHIS, TENNESSEE	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
CONGRESSMAN		HEART DISEASE		NATURAL	
EDUCATION		PREVIOUS ILLNESS		TREATMENT	
HIGH SCHOOL		NONE		NONE	
RELIGION		DATE OF BURIAL		PLACE OF BURIAL	
METHODIST		APRIL 6, 1968		MEMPHIS, TENNESSEE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		DATE	
JAMES EARL RAY		JAMES EARL RAY		APRIL 4, 1968	

RECEIVED
DEC 10 1956
BUREAU V. S.

THIS CERTIFICATE IS A PUBLIC RECORD AND IS NOT TO BE REPRODUCED OR TRANSMITTED IN ANY FORM OR BY ANY MEANS, ELECTRONIC OR MECHANICAL, INCLUDING PHOTOCOPYING, RECORDING, OR BY ANY INFORMATION STORAGE AND RETRIEVAL SYSTEM, WITHOUT PERMISSION IN WRITING FROM THE STATE DEPARTMENT OF HEALTH.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by a funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film 0208 12-17-56 et

13073

CERTIFICATE OF DEATH

13073

33v

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 2 yrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION John B. Parsons Home for Aged	
3. NAME OF DECEASED (Type or print) First Mary Middle Frances Last Robertson		4. DATE OF DEATH Month December Day 9 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 21, 1891
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Sylvester Holloway		14. MOTHER'S MAIDEN NAME Maria Disharoon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT John B. Parsons Home for the Aged Salisbury, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Uterus 174X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 6 mo	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/30 , 19 56 , to 1/4 , 19 57 , that I last saw the deceased alive on 12/9 , 19 56 , and that death occurred at 4 P M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Md DATE SIGNED 12/10/56 ACTUAL SIGNATURE L. R. Grance M.D. L. R. Grance PHYSICIAN'S NAME (Type) L. R. Grance			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/11/1956	
22c. NAME OF CEMETERY OR CREMATORY Hebron Cemetery		22d. LOCATION (City, town, or county) (State) Hebron, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Thomas H. Walker		24a. REC'D BY REGISTRAR DEC 11 1956	
ADDRESS Salisbury, Maryland		24b. REGISTRAR'S SIGNATURE Mary K. Holloway	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>	
<p>7. MARITAL STATUS</p>		<p>8. CAUSE OF DEATH</p>	
<p>9. MEDICAL HISTORY</p>		<p>10. SIGNATURE OF PHYSICIAN</p>	
<p>11. SIGNATURE OF REGISTRAR</p>		<p>12. DATE OF DEATH</p>	
<p>13. PLACE OF DEATH</p>		<p>14. TIME OF DEATH</p>	
<p>15. SIGNATURE OF WITNESS</p>		<p>16. SIGNATURE OF DECEASED</p>	
<p>17. SIGNATURE OF NEXT OF KIN</p>		<p>18. SIGNATURE OF BURIAL OFFICIAL</p>	
<p>19. SIGNATURE OF FUNERAL HOME</p>		<p>20. SIGNATURE OF CHURCH OFFICIAL</p>	
<p>21. SIGNATURE OF CEMETERY OFFICIAL</p>		<p>22. SIGNATURE OF HEALTH OFFICIAL</p>	
<p>23. SIGNATURE OF DISTRICT CLERK</p>		<p>24. SIGNATURE OF COUNTY CLERK</p>	
<p>25. SIGNATURE OF STATE CLERK</p>		<p>26. SIGNATURE OF FEDERAL CLERK</p>	
<p>27. SIGNATURE OF POSTAL CLERK</p>		<p>28. SIGNATURE OF TELEPHONE CLERK</p>	
<p>29. SIGNATURE OF RAILROAD CLERK</p>		<p>30. SIGNATURE OF AIRLINE CLERK</p>	
<p>31. SIGNATURE OF MARINE CLERK</p>		<p>32. SIGNATURE OF NAVY CLERK</p>	
<p>33. SIGNATURE OF ARMY CLERK</p>		<p>34. SIGNATURE OF AIR FORCE CLERK</p>	
<p>35. SIGNATURE OF COAST GUARD CLERK</p>		<p>36. SIGNATURE OF MARINE CORPS CLERK</p>	
<p>37. SIGNATURE OF NAVY RESERVE CLERK</p>		<p>38. SIGNATURE OF AIR FORCE RESERVE CLERK</p>	
<p>39. SIGNATURE OF ARMY RESERVE CLERK</p>		<p>40. SIGNATURE OF COAST GUARD RESERVE CLERK</p>	
<p>41. SIGNATURE OF MARINE CORPS RESERVE CLERK</p>		<p>42. SIGNATURE OF NAVY RESERVE CLERK</p>	
<p>43. SIGNATURE OF AIR FORCE RESERVE CLERK</p>		<p>44. SIGNATURE OF ARMY RESERVE CLERK</p>	
<p>45. SIGNATURE OF COAST GUARD RESERVE CLERK</p>		<p>46. SIGNATURE OF MARINE CORPS RESERVE CLERK</p>	
<p>47. SIGNATURE OF NAVY RESERVE CLERK</p>		<p>48. SIGNATURE OF AIR FORCE RESERVE CLERK</p>	
<p>49. SIGNATURE OF ARMY RESERVE CLERK</p>		<p>50. SIGNATURE OF COAST GUARD RESERVE CLERK</p>	
<p>51. SIGNATURE OF MARINE CORPS RESERVE CLERK</p>		<p>52. SIGNATURE OF NAVY RESERVE CLERK</p>	
<p>53. SIGNATURE OF AIR FORCE RESERVE CLERK</p>		<p>54. SIGNATURE OF ARMY RESERVE CLERK</p>	
<p>55. SIGNATURE OF COAST GUARD RESERVE CLERK</p>		<p>56. SIGNATURE OF MARINE CORPS RESERVE CLERK</p>	
<p>57. SIGNATURE OF NAVY RESERVE CLERK</p>		<p>58. SIGNATURE OF AIR FORCE RESERVE CLERK</p>	
<p>59. SIGNATURE OF ARMY RESERVE CLERK</p>		<p>60. SIGNATURE OF COAST GUARD RESERVE CLERK</p>	
<p>61. SIGNATURE OF MARINE CORPS RESERVE CLERK</p>		<p>62. SIGNATURE OF NAVY RESERVE CLERK</p>	
<p>63. SIGNATURE OF AIR FORCE RESERVE CLERK</p>		<p>64. SIGNATURE OF ARMY RESERVE CLERK</p>	
<p>65. SIGNATURE OF COAST GUARD RESERVE CLERK</p>		<p>66. SIGNATURE OF MARINE CORPS RESERVE CLERK</p>	
<p>67. SIGNATURE OF NAVY RESERVE CLERK</p>		<p>68. SIGNATURE OF AIR FORCE RESERVE CLERK</p>	
<p>69. SIGNATURE OF ARMY RESERVE CLERK</p>		<p>70. SIGNATURE OF COAST GUARD RESERVE CLERK</p>	
<p>71. SIGNATURE OF MARINE CORPS RESERVE CLERK</p>		<p>72. SIGNATURE OF NAVY RESERVE CLERK</p>	
<p>73. SIGNATURE OF AIR FORCE RESERVE CLERK</p>		<p>74. SIGNATURE OF ARMY RESERVE CLERK</p>	
<p>75. SIGNATURE OF COAST GUARD RESERVE CLERK</p>		<p>76. SIGNATURE OF MARINE CORPS RESERVE CLERK</p>	
<p>77. SIGNATURE OF NAVY RESERVE CLERK</p>		<p>78. SIGNATURE OF AIR FORCE RESERVE CLERK</p>	
<p>79. SIGNATURE OF ARMY RESERVE CLERK</p>		<p>80. SIGNATURE OF COAST GUARD RESERVE CLERK</p>	
<p>81. SIGNATURE OF MARINE CORPS RESERVE CLERK</p>		<p>82. SIGNATURE OF NAVY RESERVE CLERK</p>	
<p>83. SIGNATURE OF AIR FORCE RESERVE CLERK</p>		<p>84. SIGNATURE OF ARMY RESERVE CLERK</p>	
<p>85. SIGNATURE OF COAST GUARD RESERVE CLERK</p>		<p>86. SIGNATURE OF MARINE CORPS RESERVE CLERK</p>	
<p>87. SIGNATURE OF NAVY RESERVE CLERK</p>		<p>88. SIGNATURE OF AIR FORCE RESERVE CLERK</p>	
<p>89. SIGNATURE OF ARMY RESERVE CLERK</p>		<p>90. SIGNATURE OF COAST GUARD RESERVE CLERK</p>	
<p>91. SIGNATURE OF MARINE CORPS RESERVE CLERK</p>		<p>92. SIGNATURE OF NAVY RESERVE CLERK</p>	
<p>93. SIGNATURE OF AIR FORCE RESERVE CLERK</p>		<p>94. SIGNATURE OF ARMY RESERVE CLERK</p>	
<p>95. SIGNATURE OF COAST GUARD RESERVE CLERK</p>		<p>96. SIGNATURE OF MARINE CORPS RESERVE CLERK</p>	
<p>97. SIGNATURE OF NAVY RESERVE CLERK</p>		<p>98. SIGNATURE OF AIR FORCE RESERVE CLERK</p>	
<p>99. SIGNATURE OF ARMY RESERVE CLERK</p>		<p>100. SIGNATURE OF COAST GUARD RESERVE CLERK</p>	

BUREAU V. 3

EC 11 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13074

CERTIFICATE OF DEATH

Reg. Dist. No.

13074

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 641 S. Division St				d. STREET ADDRESS 641 S. Division St			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First JAMES Middle NATHANIEL Last RUARK				4. DATE OF DEATH Month DEC. Day 8th Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 18, 1885		9. AGE (In years last birthday) yrs. 71	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Lumber Mill		11. BIRTHPLACE (State or foreign country) Worcester Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Elijah James Ruark				14. MOTHER'S MAIDEN NAME Hettie Frances Layfield			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO. Unk		17. INFORMANT Mrs. Sallie James Ruark (Wife) Address 641 S. Division St. Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Decomposition DUE TO (c) Cerebral Vascular disease - Reported Stroke							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-1, 1956 , to 12-8, 1956 , that I last saw the deceased alive on 12-8, 1956 , and that death occurred at 8:10 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE W. B. Smith				ADDRESS (Street, city or town, state) Medical Center		DATE SIGNED Dec. 1956	
PHYSICIAN'S NAME (Type) Dr. William B. Smith M.D.				Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 1956		22c. NAME OF CEMETERY OR CREMATORY Parsonsborg, Meth Church Cem.		22d. LOCATION (City, town, or county) (State) Parsonsborg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				ADDRESS DEC 11 1956		24a. REC'D BY REGISTRAR Mary H. Holloway	

1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

13075

CERTIFICATE OF DEATH

Reg. Dist. No. _____

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MIDDLESEX		STATE <u>MARYLAND</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Salisbury</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>724 Delaware Street</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Jo Ann SAUSAGE</u>				<u>December 27, 1956</u>			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
<u>Female</u>		<u>Colored</u>		<u>Single</u>		<u>June 4, 1936</u>	
9. AGE last birthday		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<u>6</u>		<u>none</u>		<u>none</u>		<u>Salisbury Md</u>	
12. CITIZEN OF WHAT COUNTRY		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
<u>U.S.A.</u>		<u>Brooks Savage</u>		<u>May Lee Justice</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>2</u>		<u>May Lee Savage</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
340.3 IMMEDIATE CAUSE (A)				<u>Massive Cerebral edema + damage</u>			
ANTECEDENT CAUSE(S) DUE TO				<u>? meningitis, etiology</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				<u>undetermined</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>Pneumonia Rt lower lobe</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. VAULT OPEN?		INTERVAL BETWEEN ONSET AND DEATH	
				<u>YES</u> <input checked="" type="checkbox"/> <u>NO</u> <input type="checkbox"/>		<u>2 days</u>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
		<input type="checkbox"/> <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>Dec 25, 1956</u> to <u>Dec 27, 1956</u>, that I last saw the deceased alive on <u>Dec 26, 1956</u>, and that death occurred at <u>4:10 P.M.</u> from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)			
<u>R. H. Sullivan</u>				<u>M.D. 976 N. Division St. Salisbury, Md</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12/29/56</u>		<u>Green Acres Cem</u>		<u>Salisbury Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>1-7-57</u>		<u>Mary W. Holloman</u>		<u>Barker M. West</u>		<u>Salisbury</u>	

20821376 XV5

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

BUREAU V. 3

JAN 8 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13076

CERTIFICATE OF DEATH

Reg. Dist. No.

13076

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital				d. STREET ADDRESS R.D.# 1 (Shad Point)			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First FLORIAN Middle SCHIEBEL Last SCHIEBEL				4. DATE OF DEATH Month DEC. Day 8 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 3, 1875		9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months 7 Days 5	IF UNDER 24 HRS. Hours 5 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Machine		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John Schiebel				14. MOTHER'S MAIDEN NAME Mary Zimer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO. Unk		17. INFORMANT Mrs. Mary Schiebel (Wife) R.D.# 1 (Shad Point) Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 420.0 DUE TO (c) 420.0 DUE TO							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 12/7 , 19 56 , to 12/8 , 19 56 , that I last saw the deceased alive on 12/8 , 19 56 , and that death occurred at P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Medical Center DATE SIGNED Dec. 10, 1956							
ACTUAL SIGNATURE Wilber R. Ellis Jr. M.D. Salisbury, Maryland							
PHYSICIAN'S NAME (Type) Dr. Wilber R. Ellis Jr. M.D. Salisbury, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF Dec. 12, 1956		22c. NAME OF CEMETERY OR CREMATORY J. Wm. Lee & Son Co. Funeral Home - Washington D.C.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				24a. REC'D BY REGISTRAR DEC 11 1956		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

13077

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u> COUNTY <u>Somerset</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <u>Salisbury</u>		LENGTH OF STAY (In this place) <u>Since 6/6/56</u>		CITY OR TOWN <u>Princess Anne</u>		<u>19X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pine Bluff State Hospital Salisbury, Maryland</u>				STREET ADDRESS (If rural give location) <u>Hampton Avenue</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Albert</u> <u>-</u> <u>Solum</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Dec.</u> <u>16</u> <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Sept. 20, 1901</u>	9. AGE last birthday <u>55</u> yrs.	IF UNDER 1 YEAR Months <u>2</u> Days <u>26</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Wisconsin</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Iver Solum</u>				14. MOTHER'S MAIDEN NAME <u>Helen Guttland</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Lost</u>		17. INFORMANT & ADDRESS <u>Patient when admitted to hospital</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Chronic Heart Disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Nephritis</u>						<u>5 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Arrested Tuberculosis</u>						<u>1 yr.</u>	
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 6</u> , 19 <u>56</u> , to <u>Dec. 16</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec. 16</u> , 19 <u>56</u> , and that death occurred at <u>6:45</u> a.m. from the causes and on the date stated above.							
SIGNATURE <u>Lee L. Lawrence</u>		M.D.		ADDRESS (Street, city, town, state) <u>Fruitland, Md.</u>		DATE SIGNED <u>12/16/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12-18-1956</u>		NAME OF CEMETERY OR CREMATORY <u>Perryshaw Cemetery, Princess Anne, Md.</u>		LOCATION (City, town, or county) (State) <u>Princess Anne, Md.</u>	
24. REC'D BY REGISTRAR <u>DEC 21 1956</u>		REGISTRAR'S SIGNATURE <u>Mary H. Kelly</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Levin B. Wilson</u>		ADDRESS <u>Princess Anne, Md.</u>	

CERTIFICATE OF DEATH

Form 10-1-54

1. NAME OF DECEASED

2. AGE OF DECEASED

3. SEX

4. RACE

5. OCCUPATION

6. CAUSE OF DEATH

7. DATE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. MEDICAL CERTIFICATE

14. SIGNATURE OF DECEASED

15. SIGNATURE OF DECEASED

16. SIGNATURE OF DECEASED

17. SIGNATURE OF DECEASED

18. SIGNATURE OF DECEASED

BUREAU V. S.

DEC 21 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

13092

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 7 Yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rt. # 4				d. STREET ADDRESS Salisbury Rt. #4			
3. NAME OF DECEASED (Type or print) JOHN FRANCIS SULLIVAN				4. DATE OF DEATH 12 7 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 13, 1900	
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper				10b. KIND OF BUSINESS OR INDUSTRY Masten Truck Co.		11. BIRTHPLACE (State or foreign country) Maine	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Timothy Sullivan				14. MOTHER'S MAIDEN NAME Margaret O'Brien			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 212-01-3983		17. INFORMANT Sullivan Address Mrs. Vance Davis, Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Melanotic Carcinoma 190X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 3 mon	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 6, 1956 to 12-7 1956 what I last saw the deceased olive on 12-6-56 12, and that death occurred at 8 A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Lee L Lawry M.D. Fruitland, Md.				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) Dr. Lee Lawry, Fruitland, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/10/56		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. Salisbury, Maryland				24a. REC'D BY REGISTRAR 12-8-56		24b. REGISTRAR'S SIGNATURE Mary W. Holloway	

Norman T. Baker

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 65		4. RACE White		5. DATE OF DEATH Dec 11 1956		6. PLACE OF DEATH Home	
7. OCCUPATION Retired		8. CAUSE OF DEATH Heart Disease		9. MANNER OF DEATH Natural		10. SIGNATURE OF PHYSICIAN J. H. Harris		11. SIGNATURE OF DECEASED J. H. Harris		12. SIGNATURE OF WITNESSES J. H. Harris	
13. DATE OF BIRTH Dec 11 1956		14. PLACE OF BIRTH Maryland		15. DATE OF DEATH Dec 11 1956		16. PLACE OF DEATH Home		17. SIGNATURE OF PHYSICIAN J. H. Harris		18. SIGNATURE OF DECEASED J. H. Harris	
19. OCCUPATION Retired		20. CAUSE OF DEATH Heart Disease		21. MANNER OF DEATH Natural		22. SIGNATURE OF PHYSICIAN J. H. Harris		23. SIGNATURE OF DECEASED J. H. Harris		24. SIGNATURE OF WITNESSES J. H. Harris	
25. DATE OF BIRTH Dec 11 1956		26. PLACE OF BIRTH Maryland		27. DATE OF DEATH Dec 11 1956		28. PLACE OF DEATH Home		29. SIGNATURE OF PHYSICIAN J. H. Harris		30. SIGNATURE OF DECEASED J. H. Harris	
31. OCCUPATION Retired		32. CAUSE OF DEATH Heart Disease		33. MANNER OF DEATH Natural		34. SIGNATURE OF PHYSICIAN J. H. Harris		35. SIGNATURE OF DECEASED J. H. Harris		36. SIGNATURE OF WITNESSES J. H. Harris	

BUREAU V. S.

DEC 11 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13093

CERTIFICATE OF DEATH

13079

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebron				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebron			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route # 1.				d. STREET ADDRESS Route # 1.			
3. NAME OF DECEASED (Type or print) First Hilary Middle Taylor Last Taylor				4. DATE OF DEATH Month Dec. Day 24. Year 19 56.			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 12, 1885.	9. AGE (In years last birthday) 71. yrs.	IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.	IF UNDER 24 HRS. Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Rockwalkin, Md. Wico. Co. Md. U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew Taylor				14. MOTHER'S MAIDEN NAME Ella Truitt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Lala E. Taylor (Wife) Address Route # 1.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic Myocarditis 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic nephritis						INTERVAL BETWEEN ONSET AND DEATH 1 year	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 1956 to Dec 23, 1956 , that I last saw the deceased alive on Dec 23, 1956 , and that death occurred at 1.55 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE William Emrich M.D.				ADDRESS (Street, city or town, state) Hebron, Maryland DATE SIGNED Dec. 24-56			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF Dec. 27. 56		22c. NAME OF CEMETERY OR CREMATORY Hebron, Maryland. Cemetery.		22d. LOCATION (City, town, or county) (State) Hebron, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Holloway & Company.				ADDRESS Salisbury, Maryland.		24a. REC'D BY REGISTRAR DEC 27 1956	
				24b. REGISTRAR'S SIGNATURE Mary H. Holloway			

CERTIFICATE OF DEATH

NAME OF DECEASED [Illegible]		SEX [Illegible]		AGE [Illegible]	
DATE OF DEATH [Illegible]		PLACE OF DEATH [Illegible]		COUNTY [Illegible]	
TIME OF DEATH [Illegible]		CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]	
PLACE OF BIRTH [Illegible]		DATE OF BIRTH [Illegible]		SEX [Illegible]	
OCCUPATION [Illegible]		MARITAL STATUS [Illegible]		EDUCATION [Illegible]	
PREVIOUS ILLNESS [Illegible]		MEDICAL HISTORY [Illegible]		SURVIVAL [Illegible]	
SIGNATURE OF DECEASED [Illegible]		SIGNATURE OF WITNESS [Illegible]		SIGNATURE OF PHYSICIAN [Illegible]	
SIGNATURE OF CORONER [Illegible]		SIGNATURE OF JURY [Illegible]		SIGNATURE OF JUDGE [Illegible]	
SIGNATURE OF CLERK [Illegible]		SIGNATURE OF REGISTRAR [Illegible]		SIGNATURE OF CHIEF CLERK [Illegible]	

BUREAU V. S.

DEC 27 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13080

Reg. Dist. No.

332

13078

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
c. LENGTH OF STAY IN lb <u>Most of life</u>				d. STREET ADDRESS <u>524 Delaware St.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>At home - 524 Delaware St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Carroll</u> Middle <u>James</u> Last <u>Trader</u>				4. DATE OF DEATH Month <u>12</u> Day <u>29</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>A.A.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-18-1889</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Factory work.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Campbell Soups.</u>			
11. BIRTHPLACE (State or foreign country) <u>Salisbury, Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>			
13. FATHER'S NAME <u>Elijah Trader</u>				14. MOTHER'S MAIDEN NAME <u>Georgianna Fooks</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes</u> <u>WWI</u>				16. SOCIAL SECURITY NO. <u>220-10-8364</u>			
17. INFORMANT <u>Mrs. Amanda Trader</u>				Address <u>524 Delaware St. Salisbury</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.0 DUE TO <u>arterio-sclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u> </u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Earl L. Royer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>12-31-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-2-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Old Hickory Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Slaughter Neck, Del.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Stewart Funeral Home, Salisbury, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 4 1957</u>			
				24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

7 JAN 4 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13079

CERTIFICATE OF DEATH

13081

Reg. Dist. No. 337

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 619 Fitzwater St				d. STREET ADDRESS 619 Fitzwater St.			
3. NAME OF DECEASED (Type or print) First SALLIE Middle ELLEN Last TRUITT				4. DATE OF DEATH Month DECEMBER Day 22nd Year 19 56			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 16, 1903	9. AGE (In years last birthday) 53 yrs.	IF UNDER 1 YEAR Months 4 Days 6	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Willards, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Talton Baker				14. MOTHER'S MAIDEN NAME Janie Bowden			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Thelma Cox (Daughter) Address Tyaskin, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 422.2 DUE TO Myocardial degeneration Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 5 days 1 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from 6 , 19 54 , to 12-22 , 19 56 , that I last saw the deceased alive on 12-21-56 , 19 , and that death occurred at 8:00 A. M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Dr. Earl Beardsley			ADDRESS (Street, city or town, state) Maryland Ave. (Office)		DATE SIGNED Dec. 22 1956		
PHYSICIAN'S NAME (Type) Dr. Earl Beardsley			Salisbury, Maryland				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 26, 1956	22c. NAME OF CEMETERY OR CREMATORY Cooper Cemetery	22d. LOCATION (City, town, or county) (State) R. D. # Willards, Maryland				
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.			24a. REC'D BY REGISTRAR DEC 27 1956		24b. REGISTRAR'S SIGNATURE Thelma Cox		

BUREAU V. S.

DEC 27 1956

RECEIVED

1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

13080

13082

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u>		LENGTH OF STAY (In this place) <u>Since 6/14/50</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hurlock</u>		<u>99X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pine Bluff State Hospital Salisbury, Maryland</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Hugh</u> <u>Pete</u> <u>Vinson</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>December 4</u> <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept. 15, 1889</u>	9. AGE last birthday <u>67</u> yrs.	IF UNDER 1 YEAR Months <u>2</u> Days <u>19</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Minister</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baptist Church</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Floyd Vinson</u>				14. MOTHER'S MAIDEN NAME <u>Belle Garriss</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Patient when admitted to hospital</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
002x IMMEDIATE CAUSE (A) <u>pulmonary tuberculosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1945</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u></u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u></u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 14, 1950</u> , to <u>Dec. 4, 1956</u> , that I last saw the deceased alive on <u>Dec. 4, 1956</u> , and that death occurred at <u>7:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>S. H. Muller</u> M.D.				ADDRESS (Street, city, town, state) <u>Salisbury, Maryland</u>		DATE SIGNED <u>12/4/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 7, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Washington Cemetery</u>		LOCATION (City, town, or county) (State) <u>Hurlock, Maryland</u>	
24. REC'D BY REGISTRAR DATE <u>12-7-56</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Trampton</u>		ADDRESS <u>22 Federal Highway</u>	

CERTIFICATE OF DEATH

FILE NO.

1. DECEASED'S NAME (Last, first, middle)

2. PLACE OF BIRTH

3. SEX

4. AGE (Years, months, days)

5. DATE OF BIRTH

6. PLACE OF DEATH

7. TIME OF DEATH

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CLERK

14. SIGNATURE OF REGISTRAR

15. SIGNATURE OF JUDGE

16. SIGNATURE OF SHERIFF

17. SIGNATURE OF CORONER

18. SIGNATURE OF DISTRICT ATTORNEY

19. SIGNATURE OF COUNTY CLERK

20. SIGNATURE OF CITY CLERK

21. SIGNATURE OF VICE-MAYOR

22. SIGNATURE OF ALDERMAN

23. SIGNATURE OF COMMON COUNCIL

24. SIGNATURE OF BOARD OF HEALTH

25. SIGNATURE OF BOARD OF EDUCATION

26. SIGNATURE OF BOARD OF SUPERVISORS

27. SIGNATURE OF BOARD OF CHURCHES

28. SIGNATURE OF BOARD OF SCHOOLS

29. SIGNATURE OF BOARD OF AGENCIES

30. SIGNATURE OF BOARD OF CHARITIES

31. SIGNATURE OF BOARD OF LITERATURE

32. SIGNATURE OF BOARD OF ARTS

33. SIGNATURE OF BOARD OF MUSIC

34. SIGNATURE OF BOARD OF THEATRE

35. SIGNATURE OF BOARD OF CINEMA

36. SIGNATURE OF BOARD OF RADIO

37. SIGNATURE OF BOARD OF TELEVISION

38. SIGNATURE OF BOARD OF PUBLICATIONS

39. SIGNATURE OF BOARD OF RECORDS

40. SIGNATURE OF BOARD OF ARCHIVES

41. SIGNATURE OF BOARD OF LIBRARIES

42. SIGNATURE OF BOARD OF MUSEUMS

43. SIGNATURE OF BOARD OF GARDENS

44. SIGNATURE OF BOARD OF PARKS

45. SIGNATURE OF BOARD OF RECREATION

46. SIGNATURE OF BOARD OF AMUSEMENTS

47. SIGNATURE OF BOARD OF CONVENTIONS

48. SIGNATURE OF BOARD OF EXHIBITIONS

49. SIGNATURE OF BOARD OF Fairs

50. SIGNATURE OF BOARD OF GAMES

51. SIGNATURE OF BOARD OF SPORTS

52. SIGNATURE OF BOARD OF YACHTING

53. SIGNATURE OF BOARD OF HUNTING

54. SIGNATURE OF BOARD OF FISHING

55. SIGNATURE OF BOARD OF BOWLING

56. SIGNATURE OF BOARD OF GOLF

57. SIGNATURE OF BOARD OF TENNIS

58. SIGNATURE OF BOARD OF BASEBALL

59. SIGNATURE OF BOARD OF SOFTBALL

60. SIGNATURE OF BOARD OF VOLLEYBALL

61. SIGNATURE OF BOARD OF BASKETBALL

62. SIGNATURE OF BOARD OF HOCKEY

63. SIGNATURE OF BOARD OF RUGBY

64. SIGNATURE OF BOARD OF CRICKET

65. SIGNATURE OF BOARD OF FOOTBALL

66. SIGNATURE OF BOARD OF RUGBY

67. SIGNATURE OF BOARD OF CRICKET

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95. SIGNATURE OF BOARD OF FOOTBALL

96. SIGNATURE OF BOARD OF RUGBY

97. SIGNATURE OF BOARD OF CRICKET

98. SIGNATURE OF BOARD OF FOOTBALL

99. SIGNATURE OF BOARD OF RUGBY

100. SIGNATURE OF BOARD OF CRICKET

BUREAU V. 2

DEC 10 1956

RECEIVED

1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

13083

CERTIFICATE OF DEATH

13081

Reg. Dist. No. 337

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Wicomico</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Wicomico</u>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u>	LENGTH OF STAY (In this place) <u>2 wks</u>	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Willards</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pen. Gen. Hospital</u>		STREET ADDRESS (If rural give location) <u>Main St</u>	
3. NAME OF DECEASED (Type or Print) <u>ROSA B WILKINS</u>		4. DATE OF DEATH (Month) <u>Dec.</u> (Day) <u>30th</u> (Year) <u>19 56</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>August 7, 1887</u>
9. AGE last birthday <u>69</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>23</u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>Liberty Town, Worcester Co. Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>			
13. FATHER'S NAME <u>Garrison Nicholson</u>		14. MOTHER'S MAIDEN NAME <u>Sallie</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMATION & ADDRESS <u>Mr. Eschol J. Adkins (Son) R.D. # 4</u> <u>Salisbury, Maryland</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		15. MEDICAL CERTIFICATION	
260X IMMEDIATE CAUSE (A) <u>Profound Ulcers</u>		INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Debris - mullus</u>		<u>years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Massive Posterior Coronary</u>		<u>Immediate</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>Ulcer Protrusion</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12:17</u>, 19<u>56</u>, to <u>12:30</u>, 19<u>56</u>, that I last saw the deceased alive on <u>12:30</u>, 19<u>56</u>, and that death occurred at <u>11:56</u> M., from the causes and on the date stated above.			
SIGNATURE <u>H. B. B. B.</u>		ADDRESS (Street, city, town, state) <u>Medical Center</u>	
DATE SIGNED <u>12-30-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan. 2, 1957</u>	
NAME OF CEMETERY OR CREMATORY <u>Willards Cemetery</u>		LOCATION (City, town, or county) (State) <u>Willards, Maryland</u>	
24. REC'D BY REGISTRAR <u>Jan 3 1957</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY - SALISBURY, MARYLAND</u>	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p> <p>7. CAUSE OF DEATH</p> <p>8. PLACE OF DEATH</p> <p>9. DATE OF DEATH</p> <p>10. SIGNATURE OF PHYSICIAN</p> <p>11. SIGNATURE OF REGISTRAR</p> <p>12. SIGNATURE OF WITNESSES</p>		<p>13. NAME OF PHYSICIAN</p> <p>14. ADDRESS OF PHYSICIAN</p> <p>15. SIGNATURE OF PHYSICIAN</p> <p>16. DATE OF DEATH</p> <p>17. PLACE OF DEATH</p> <p>18. SIGNATURE OF REGISTRAR</p> <p>19. SIGNATURE OF WITNESSES</p>
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BUREAU V. R.

JAN 3 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13094

CERTIFICATE OF DEATH

Reg. Dist. No.

13084

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Willards				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Willards			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Route #50				d. STREET ADDRESS U.S. Route # 50			
3. NAME OF DECEASED (Type or print) First LULU Middle ELSIE Last WILLIAMS				4. DATE OF DEATH Month DECEMBER Day 18th Year 19 56			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 11, 1900		9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Powellville, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John E. Williams				14. MOTHER'S MAIDEN NAME Cleora Burbage			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. John E. Williams (Father) Address U.S. Route #50 Willards, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocarditis 447X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension - arteriosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 weeks 2 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obesity							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Dec 4 , 19 56 , to 12-18 , 19 56 , that I last saw the deceased alive on 12-18-56 , 19 56 , and that death occurred at 70 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Frank R. Lewis				ADDRESS (Street, city or town, state) Willards, Maryland		DATE SIGNED Dec. 18 1956	
PHYSICIAN'S NAME (Type) Dr. Frank R. Lewis M.D.				X			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 20, 1956		22c. NAME OF CEMETERY OR CREMATORY Burbage Family Cemetery		22d. LOCATION (City, town, or county) Powellville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD				ADDRESS SALISBURY, MD		24a. REC'D BY REGISTRAR DEC 26 1956	
				24b. REGISTRAR'S SIGNATURE Mary H. Holloway			

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

DEC 26 1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13095

CERTIFICATE OF DEATH

13085

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebron				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebron			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Main St				d. STREET ADDRESS Main St			
3. NAME OF DECEASED (Type or print) First LOUIS Middle MARTIN Last WILSON				4. DATE OF DEATH Month DECEMBER Day 1 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 16, 1897		9. AGE (In years last birthday) yrs. 59	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee (Laborer)		10b. KIND OF BUSINESS OR INDUSTRY Elywood Co.		11. BIRTHPLACE (State or foreign country) Suffolk, Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Allison W. Wilson				14. MOTHER'S MAIDEN NAME Sarah Rebecca Bradley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Dora Veasey (Sister) Address 273 Diamond St. Philadelphia, Pa.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gonorrhea Herpesvirus 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 2 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 29, 1956 , to Dec. 1, 1956 , that I last saw the deceased alive on Dec. 1, 1956 , and that death occurred at 3:30 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE William Emrich M.D.				ADDRESS (Street, city or town, state) Main St. (Office) DATE SIGNED Dec. 9- 1956			
PHYSICIAN'S NAME (Type) Dr. William Emrich M.D.				Hebron, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 4, 1956		22c. NAME OF CEMETERY OR CREMATORY Hebron, Cemetery		22d. LOCATION (City, town, or county) (State) Hebron, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				24a. REC'D BY REGISTRAR DEC 5 1956		24b. REGISTRAR'S SIGNATURE Mary H. Holloway	

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DEC 5 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13082

CERTIFICATE OF DEATH

Reg. Dist. No.

13120

337

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore County</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>4 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Young</u> Last <u>Young</u>		4. DATE OF DEATH Month <u>December</u> Day <u>25</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/16/1903</u>
9. AGE (In years lost birthday) <u>53</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Rollins</u>		14. MOTHER'S MAIDEN NAME <u>Mayhalia Rollins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Degenerative heart disease</u> DUE TO (c) <u>-</u>		INTERVAL BETWEEN ONSET AND DEATH <u>20 min.</u> <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rheumatoid arthritis, chronic</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>o. 11.</u> Month <u>19</u> Day <u>19</u> Year <u>1956</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 24, 1952</u> , to <u>Dec. 25, 1956</u> , that I last saw the deceased alive on <u>Dec. 25, 1956</u> , and that death occurred at <u>8:55 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dr. J. Guerman</u>		ADDRESS (Street, city or town, state) <u>Deer's Head State Hospital</u>	
PHYSICIAN'S NAME (Type) <u>V. Guerman, M.D.</u>		DATE SIGNED <u>12/26/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/30/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Nt Calvary Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Brooklyn Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Elroy O. Wilson</u>		24a. REC'D BY REGISTRAR DATE <u>1/8/57</u>	
ADDRESS <u>2004 Orlean St</u>		24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

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21 JAN 21 1957

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